S. HRG. 99-756

REFORM OF MEDICARE PAYMENT FOR CAPITAL COSTS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-NINTH CONGRESS

SECOND SESSION

MARCH 14, 1986

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE
62-577 O WASHINGTON : 1986

For sale by the Superintendent of Documents, Congressional Sales Office
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S361-91

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REFORM OF MEDICARE CAPITAL PAYMENTS FOR CAPITAL COSTS

FRIDAY, MARCH 14, 1986

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Washington, DC.

The committee met, pursuant to notice, at 9:35 a.m., in room SD-215, Dirksen Senate Office Building, Hon. David Durenberger (chairman) presiding.

Present: Senators Durenberger, Baucus, and Bradley.

[The press release announcing the hearing, the opening statements of Senators Durenberger, Dole, and Bradley and a background paper by CRS follow:]

[Press Release No. 86-009]

FINANCE COMMITTEE, SUBCOMMITTEE ON HEALTH TO EXAMINE PROPOSALS TO REFORM MEDICARE PAYMENT FOR CAPITAL COSTS

Proposals for the reform of Medicare payments for hospital capital costs will be reviewed at a Committee on Finance Subcommittee on Health hearing March 14, 1986, Chairman Bob Packwood (R-Oregon) said today.

Senator Packwood said the hearing would begin at 9:30 a.m., Friday, March 14, 1986, in Room SD-215 of the Dirksen Senate Office Building in Washington.

Senator Packwood said Senator David Durenberger (R-Minnesota), Chairman of the Subcommittee on Health, would preside at the March 14 capital payment reform hearing.

When Congress passed the Social Security Amendments of 1983, it established October 1, 1986, as the target date for effecting reforms in Medicare's capital cost payment methodology, Senator Packwood explained.

The Administration included such a proposal in the Federal Budget for Fiscal Year 1987. Additionally, Senator Durenberger is expected to offer his own version of how capital costs should be included in Medicare's prospective payment system. That proposal is expected to be offered as a Senate bill the week of February 24.

Chairman Packwood said the Subcommittee on Health expects to receive testimony from Administration officials, as well as representatives of the hospital industry and the nation's financial community to whom the health care industry looks for funding.

STATEMENT OF SENATOR DAVE DURENBERGER

Today's hearing is devoted to Medicare capital payment reform. Capital expenditures were exempted from the Part A prospective payment system when PPS was created three years ago. But the Congress made clear its intention to include capital in the system, and set itself a deadline of October 1, 1986. In the meantime, the Secretary of Health and Human Services was instructed to prepare legislative recommendations to fold capital payments into PPS.

Last November this subcommittee heard testimony from the Acting Assistant Secretary for Planning and Evaluation for HHS, reviewing their progress on the HHS study of this issue. Since that time the Administration has made public its proposal for incorporating capital payment into the prospective payment system, through regulation.

This proposal calls for a four-year transition period. According to the President's budget figures, it would Reduce capital payments to American hospitals in FY 1987 $456 million, and by $11.5 billion through FY 1991.

The Medicare financing reforms begun by the Social Security Amendments of 1983 were designed to save money for those who benefit from and those who finance the Medicare trust fund. They were not designed to actively undermine efficient as well as inefficient hospitals. It was not the intent of the 97th Congress back in 1983 and I do not believe it is the intent of the 99th Congress today to use reform of Medicare Capital payments for deficit reduction.

Recently, I introduced with my colleague from Indiana, Senator Quayle, S. 2121, a proposal to incorporate capital expenditures into PPS. The title of that bill, the Fair Deal Capital Payment Act of 1986, has drawn a few snickers since its introduction. There was a particular reason for choosing that name-and it didn't have anything to do with Harry Truman.

Some of you have heard me talk about prospective payment as a contract between the federal government and the health care industry. It's a deal we struck to improve the way health care is financed and delivered in our nation.

But if PPS is a deal, it has to be a fair deal, and both sides have to stick to the original terms: Health care providers cut costs and improve both efficiency and quality of service. Washington gives providers realistic rational payment for the services rendered.

In fact some in Washington would have us renege on that deal, using Medicare as a whipping boy for a bloated federal budget fed by irresponsible spending policy in other areas. This should not and will not continue. Any savings from Part A reform—and they are substantial—must benefit the Medicare trust and fund for future beneficiaries, not continue wasteful spending for this generation.

The hearing this morning will provide an opportunity for Senator Quayle and myself to perfect S. 2121. Our intent is to take this proposal, refine it and see a capital payment policy in law by October 1 of this year, made by this nation's policymakers, not by its regulators. Despite the personal popularity of our President and the unpopularity of his incredible national deficit, this is still a nation of laws rather than of men.

The Chairs and ranking members of the authorizing health subcommittees carried that message to the Secretary of HHS yesterday. This hearing should provide a similar message today. Now let's see what we can all learn from those who are expert in the details and costs of hospital investment.

STATEMENT OF SENATOR BOB DOLE

Mr. Chairman, I welcome this hearing and I compliment the distinguished Chairman for his and Senator Quayle's considerable contribution to this important subject. As we clearly signaled in the Social Security Amendments of 1983, now is the time to tackle the way we reimburse hospitals for capital expenditures. I do wish we could have had the benefit of the capital cost report from the administration, as we requested three years ago. Perhaps we will derive some benefit from that study today. I hope so. And we do have the benefit of hearing from these knowledgeable and capable witnesses who have agreed to offer their contribution to this complex and important subject.

In our deliberations, I hope we seriously take into account those institutions that are particularly at risk in our health care system. In particular, I want to emphasize my concern for rural hospitals. They already have difficulty obtaining access to debt capital. While I most certainly agree that the capital cost pass through has contributed its share to excess spending and there can be no questions that this industry is overcapitalized, I am convinced that we can move toward a more fiscally prudent approach that does not place an even greater burden of our vulnerable hospitals.

I want to thank our witnesses for joining us today. I look forward to your testimony.

STATEMENT OF SENATOR BILL BRADLEY

Mr. Chairman, yesterday I met with Dr. James Glenn from Mount Sinai Medical Center in New York regarding the Administration's Medicare capital proposal. He raised many thoughtful questions on the problems this proposal would present to his hospital.

Dr. Glenn asked me to submit his testimony on behalf of the Coalition for Fair Capital Reimbursement for the record.

TESTIMONY OF THE MOUNT SINAI MEDICAL CENTER ON BEHALF OF THE COALITION FOR FAIR CAPITAL REIMBURSEMENT BEFORE THE SUBCOMMITTEE ON HEALTH SENATE COMMITTEE ON FINANCE

MARCH 14, 1986

Mr. Chairman and Members of the Subcommittee, my name is Dr. James Glenn, Chief Executive Officer of the Mount Sinai Medical Center. I am pleased to add my comments to those of C. Edward Schwartz of the University of Minnesota Hospitals and Clinics on the subject of capital reimbursement under the Medicare Program. We are here on behalf of the Coalition for Fair Capital Reimbursement, an ad hoc group of similarly situated major teaching hospitals. The members of the Coalition are vitally concerned about various proposals now being considered by the Congress to incorporate capital costs into the Medicare Prospective Payment System (PPS), as it is directed to do by October 1, 1986.

Although still in the formative process, the Coalition already includes a number of the Nation's most renowned teaching hospitals -- specifically, Brigham and Women's Hospital, the University of Michigan Hospitals, University of Minnesota Hospitals and Clinics, Montefiore Medical Center (New York), the New York Hospital, the Presbyterian Hospital in the City of New York at Columbia-Presbyterian Medical Center, the Stanford University Hospital, St. Luke's-Roosevelt Hospital Center, the University of Virginia Hospitals, University of Washington Hospital and the University of West Virginia Hospital. Each of these nationally recognized institutions has undertaken a mandatory renovation project involving substantial capital obligations in good faith reliance upon the law in effect prior to the enactment of the prospective payment system. All of these projects replace aged physical plants which no longer can be adapted to the requirements of modern medical care.

At the outset, I would like to say the Coalition fully recognizes that national health policy -- like so many other areas of our Federal budget -- must reflect the changing circumstances of rising deficits. The Coalition does not wish to obstruct either legitimate deficit reduction efforts or the carefully considered and planned incorporation of capital reimbursement into the prospective payment system. What the Coalition does wish to convey to Members of the Subcommittee, however, is that the Administration's proposal for capital reimbursement, as set forth in the President's budget for FY 1987, is grossly deficient in its failure to provide an adequate transition mechanism for the renovation projects already underway at hospitals such as those of the Coalition. Although the provisions of S. 2121 as introduced by the Chairman of this Subcommittee are considerably more favorable than those of the Administration's proposal, in our opinion they do not go far enough in recognizing the severe impact of this profound policy change on institutions such as those in the Coalition. The Coalition members face severe financial harm under both proposals unless an adequate transition is permitted for major renovation projects that predate the advent of the prospective payment system. We appreciate this opportunity to explain the impact of these proposals on our institutions and to provide the Subcommittee with suggestions for ways to alleviate the adverse effects of a precipitous transition to prospective reimbursement for capital. We hope to be able to work closely with the Subcommittee as legislation is drafted on this complex but critical health care issue.

As pointed out by the Washington Post in its editorial of February 19, 1986, to fold capital costs into PPS without understanding the specific consequences of the new reimbursement policy makes no sense. Despite a legislative directive to study the matter and to report to Congress by October 1985 on methods for incorporating capital into the prospective payment system, the Administration is threatening to implement a prospective reimbursement methodology for capital without releasing any data on the effects of its proposal. Before the Administration is permitted to adopt a new reimbursement system for capital, there must be a thorough understanding of its impact on hospitals around the country. We hope, of course, that Congress will act this year to establish a reasonable transition to prospective reimbursement for capital. Should the legislative process not move forward as planned we would urge this Subcommittee to consider the imposition of a moratorium on administrative action such as that proposed by HHS. There is too much at stake here for Congress to permit the Executive Branch to implement an inadequate proposal conceived on the basis of incomplete, outmoded data on its impact.

To illustrate the need for transition relief, I would like to describe the Mount Sinai project and the other Coalition projects. Then, I would like to provide some preliminary estimates of the financial impact upon Coalition institutions of an abrupt change to a prospective system. The Coalition intends to submit more detailed information on financial impact to the Subcommittee in the near future -- the data is presently being assembled.

The Mount Sinai Medical Center is one of the nation's largest hospitals, with over 1,200 beds. The Mount Sinai renovation project is a major one needed to bring a severely outdated facility up to present standards. The total cost of the project is estimated at $488 million. Due to the age of its 26 separate structures -- most date from the 1904-1922 period -- the Medical Center repeatedly has been cited for life safety code and other accreditation deficiencies. Typical of Coalition members' projects, the Mount Sinai project includes a substantial reduction in beds. One hundred beds will be eliminated in the Mount Sinai renewal project and an additional 50 beds will be converted into a cost-saving day bed program.

This project is necessary in order for the Medical Center to continue in its vital role in its community. By its size alone, Mount Sinai provides the volume of services typically furnished by seven average community hospitals. In addition, the Medical Center serves as a major tertiary care center for its region, providing many services unavailable in most community hospitals. Like other Coalition members, it is also heavily committed to serving the poor -- last year, for example, it provided $15 million in charity care. Seventeen percent of its patient days and 47 percent of its outpatient visits were for Medicaid patients. The Medical Center, in effect, functions as the "family physician for East Harlem."

Projects of the magnitude of Mount Sinai's require years for planning and execution. Planning for the Mount Sinai project began in 1977. The internal planning stage required over two years. The Certificate of Need application for the project was filed in 1981. I believe that it is very significant that the Medical Center, like the other Coalition members, undertook significant steps toward the completion of its project, including the obligation of substantial sums, prior to the enactment of prospective payment. The Medical Center expended over $8.5 million in architectural and consultant fees for the project prior to 1983. Due to the project's scope and an earlier delay caused by a one-year moratorium on Certificate of Need approvals in New York State, the project will not be completed entirely until 1991.

As is the case of all the Coalition members, Mount Sinai is making a very substantial equity contribution to its project -- specifically, $110 million. The average equity contribution for Coalition members is approximately 30 percent of their respective projects' costs. This fact typifies the Coalition members' efforts to hold down financing costs by substantial commitments of whatever funds they have available or can raise through development campaigns.

The projects of the other Coalition members are similar in scope, timing, and necessity. The average age of the structures being renovated is approximately 55 years. The average project cost is approximately $250 million. The average Certificate of Need filing date for the Coalition projects was 1980, the average approval date was 1981. The planning stage for each of these projects has entailed considerable expenditures for architects, engineers and other consultants prior to the enactment of prospective payment. The average commencement date of construction was 1983, and the average completion date is 1988.

It is critical to recognize that under traditional Medicare reimbursement principles, which require capitalization of all construction period costs, the costs of these projects would not begin to be reimbursed until the projects are completed. Thus, because the average completion date is 1988, basing reimbursement during a transition period upon 1986 costs generally would deny any recognition of the costs of these projects.

The impact of the Administration's proposal upon Mount Sinai would be severe. Under the Administration's proposal for capital, the Medical Center would experience large operating deficits for many years unless services were substantially curtailed. The Medical Center has made some rough estimates of the dollar impact of the Administration's proposal compared to continued reimbursement for capital based upon actual costs. Even assuming very favorable Medicare reimbursement policies in the future (the estimates and the assumptions upon which they are based are set forth in the attachment at the end of this statement), the losses under the capital proposal are alarming. At its peak in 1992, the annual capital shortfall would be roughly $24 million. The capital shortfall for the decade 1991-2000 would be roughly $211 million in the aggregate. Although it is impossible to predict the impact upon the Medical Center's operating margin, since services would have to be curtailed to make up these staggering shortfalls, it is important to realize that the Medical Center already operates at a loss due in large measure to its strong commitment to indigent care. Mount Sinai operates a number of programs -- such as its sickle cell anemia, drug treatment, and adolescent obstetrical programs -- which lose substantial sums. The Medical Center would have to curtail these and other worthwhile programs and reduce the level of charity care it provides in order to offset reimbursement shortfalls of this magnitude. Savings of $25 million per year to offset the losses under the Administration's capital proposal simply cannot be realized through economy measures without significant reductions in services. Thus, the ultimate impact of the Administration's proposal would be in reduced services to the community. I would like to submit for the record our preliminary analysis of the impact of an abrupt transition to prospective payment.

For purposes of comparison, the provisions of S. 2121 would cause Mt. Sinai to experience a capital reimbursement shortfall of $14 million in 1992, with an aggregate shortfall over the period 1991-2000 of $163 million. Even this somewhat more favorable approach will necessitate massive curtailment of services. The impact on other Coalition institutions would be similar.

The Coalition believes that it would be very unfair and dangerous to change the rules with respect to necessary projects -- for which obligations were committed before the enactment of prospective payment -- in midstream without providing an adequate transition mechanism. Since the Coalition members will have capital costs averaging roughly 18 percent of operating costs, have substantial Medicare utilization (approximately 30 percent on average), and, typically, already operate at or near a loss, the new reimbursement policy as proposed by the Administration threatens them with great harm. Because of the mandatory nature of these projects, the good faith reliance upon prior law, and the important role such institutions play, we believe that the Medicare share of these projects should be funded reasonably in order to permit these hospitals to continue to function adequately in the years ahead.

We have given considerable thought to various methods of alleviating problems our institutions will face when capital reimbursement is incorporated in PPS. We recommend that Congress adopt special transition provisions for institutions at or approaching the peaks of their capital cycles based upon projects undertaken prior to PPS. As a comparison of projects within the Coalition demonstrates, an extended transition period is necessary to provide fair treatment. Due to the significant variations in schedules for planning, State approvals, construction and completion of these projects, many of our projects' costs will not be recognized for reimbursement purposes until 1989-1991, even though the projects represent substantial commitments prior to 1983. Thus, several institutions in the Coalition will place their projects in service significantly after the most favorable portions of the proposed transition provisions have passed.

At the same time, many modern institutions without recent major rebuilding programs will be grossly overpaid by an early shift to a national average rate of capital reimbursement. In our opinion, there is no policy justification for overpaying such institutions without large capital needs while underpaying the most needy. Scarce funds should be allocated to those institutions with the greatest capital needs based upon their substantial capital commitments prior to the enactment of PPS. One possible approach would be to create a pool to fund necessary capital reimbursement for such projects by across-the-board reductions in future increases in DRG payments. Our preliminary analysis suggests that a reduction of as little as 0.1 percent in future DRG rate increases may be sufficient to redress this problem for the Coalition's members.

Concerning the length of the transition period which would be necessary, we would observe that bond obligations assumed by hospitals for major capital projects typically involve repayment schedules of 20 to 30 years in duration. Under these circumstances, it is clear that an extended transition period is needed to provide meaningful relief to institutions such as those in the Coalition, especially since much of the transition relief would be limited to the early years of the transition period in most of the current proposals.

The Subcommittee is well aware of other types of capital proposals which have been advanced by the health care industry. These include preserving cost-based reimbursement for "old capital" such as the Coalition projects, and creating distinctions among buildings, fixed equipment and moveable equipment. Elements of many of these proposals would be favorable to Coalition institutions, although we suspect that some may not lend themselves to helping solve the budgetary crisis facing Congress and the nation. I would like to reiterate the desire of the Coaliton to work with the Subcommittee to develop an equitable program of transition to prospective reimbursement which is responsive to the budget crisis and which protects the national health care delivery system.

MOUNT SINAI MEDICAL CENTER
ESTIMATED SHORTFALL IN REIMBURSEMENT FOR CAPITAL-RELATED COSTS

[By fiscal year, in millions of dollars]

1987	1988	1989	1990	1991	1992	1993
1	1	13	18	20	24	24

1994	1995	1996	1997	1998	1999	2000
22	21	21	20	20	20	19

Total aggregate shortfall 1991-2000 211

ASSUMPTIONS:

1. Capital add-on assumptions. The add-on for capital-related costs would be a $400 addition to the nonlabor related standardized amounts. Thus, the capital add-on would be adjusted by the DRG weights, but not the wage index. There would be a linear five-year transition period, with the hospital-specific portion of the add-on beginning at 80 percent in 1987 and declining by 20 percent per annum to zero in 1991. The hospital-specific portion of the add-on would be based upon actual costs in each year rather than 1986 or some other base period. Interest income on funded depreciation and gifts would be subject to offset against interest expense.

2. Prospective payment system assumptions. The DRG payment rates would be increased by 4 percent per annum for inflation. The present indirect medical education adjustment factor (11.59 percent for each 0.1 increase in the resident to bed ratio) would remain unchanged.

3. Hospital-specific assumptions. Despite the fact that admissions have declined by 9 percent for the period 1982-85, discharges are assumed to remain constant through the year 2000. The Medical Center's case mix index, which has not changed in several years, is assumed to remain constant. The ratio of capital costs allocable to Medicare inpatients is assumed to remain at its historical level of 43 percent.

COMMENT: Based upon the foregoing assumptions, this estimate of the shortfall in reimbursement under the projected prospective payment method for capital compared to a continued passthrough for capital is believed to be quite conservative. However, it must be stressed that these figures represent only a rough estimate. More refined data will be submitted in the future.

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HOSPITAL CAPITAL COST REIMBURSEMENT UNDER MEDICARE

Prepared for the use of the
Senate Committee on Finance

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March 11, 1986

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HOSPITAL CAPITAL COST REIMBURSEMENT UNDER MEDICARE

INTRODUCTION

From 1966 until October 1983, payments for hospital services under the Medicare program were made on the basis of certain allowed or "reasonable" costs actually incurred by participating hospitals in providing care to Medicare beneficiaries. In 1983, however, Congress enacted the prospective payment system (PPS) for paying hospitals on the basis of a prospectively determined specific amount per case, according to individual patient diagnoses. 1/ The purpose of the change in reimbursement policy was to create incentives for hospitals to improve controls over spending and resource use in serving Medicare hospital inpatients.

Not all of the expenses previously reimbursed by Medicare on a reasonable cost basis, however, were incorporated into the prospective payment scheme. For example, Congress excluded capital-related costs from the prospective payment system until October 1, 1986. Until then, these capital costs will continue to be reimbursed on a reasonable cost basis. Congress directed the Secretary of Health and Human Services (HHS) to study and report to Congress by October 20, 1984 on methods and proposals for including capital-related costs in the prospective payment system. However, the Secretary has not yet submitted the report.

1/ P.L. 98-21, the Social Security Amendments of 1983. For a discussion of the elements of Medicare's prospective payment system, see CRS Issue Brief IB83171, "Medicare: Prospective Payments for Inpatient Hospital Services."

The purpose of this paper is to review current policy regarding payments to hospitals for capital-related costs under the Medicare program. The discussion is organized in four parts. Section I provides background information on the nature of capital-related costs and historical trends in methods of financing hospital capital expenditures. Current payment policy under Medicare for capital-related costs is described in Section II. Section III summarizes major reasons for the widespread interest in changing current policy and the key issues related to the design of an alternative policy. Finally, Section IV describes recent legislative and regulatory proposals to include payments for capital-related costs in Medicare's prospective payment system.

I. BACKGROUND

This section provides a brief conceptual review of the capital-related costs that may arise when hospitals acquire durable assets such as buildings and equipment. This review describes all of the major elements of capital-related costs including rent, depreciation and interest costs and the costs of equity capital, insurance and property taxes. This discussion is followed by a summary of trends in the methods hospitals have used to finance capital expenditures over the past four decades.

A. Major Elements of Capital-Related Costs

Hospitals use capital assets such as land, buildings and equipment, together with other resources such as labor and supplies, to produce patient care services. Capital assets, however, generally differ from other resources in terms of their relative durability and cost. A new building, for example, may be expected to have an economically useful life of 30 years or more. In addition, because many capital assets such as buildings or major items of equipment are very costly, they are rarely purchased outright. Instead, the cost of acquiring capital assets is usually financed over a period of years by a combination of accumulated earnings (equity), borrowed funds and, in the case of proprietary (i.e., for-profit) hospitals, by the sale of stock (a second source of equity funds). Alternatively, the use of capital assets may be obtained by lease arrangements rather than purchase.

When hospitals acquire the use of capital assets through ownership or lease transactions, certain capital-related costs are incurred. The particular capital-related costs incurred generally depend on whether the assets are acquired by lease or purchase and, if purchased, on how the purchase is financed. Thus, if a hospital leases such assets as buildings or equipment, it must pay the related rental costs over the life of the rental agreement. If the same depreciable assets (excluding land, which cannot be used up or "depreciated") are purchased rather than leased, then depreciation expenses are generated. Depreciation expenses represent the portion of the cost or value of a durable asset that is used up each year during the useful life of the asset. This concept is based on the fact that although the full initial cost of a capital asset is incurred in the year in which it is purchased, the value of the asset is not fully used up in that year. Instead, a portion of the value of the asset (e.g., a CAT scanner) is used up during each year of its economically useful lifetime, either because it wears out physically or because it becomes obsolete over time. Thus, depreciation serves to spread the cost or value of the asset over the years in which it is actually used up.

Other elements of capital-related costs depend on the methods of financing adopted in purchasing capital assets. If the purchase is financed by borrowed funds, then interest costs are incurred for the use of those funds during the period of the loan. Costs also are incurred if the purchase is financed by the use of equity funds, i.e., accumulated earnings or the sale of stock. In this case, however, the cost is implicit rather than explicit since no actual cash expenditures analogous to interest payments occur. This cost of equity capital may be thought of as the loss of potential earnings that could have been obtained over the lifetime of the purchased assets if these funds had been invested in some other use. This element of capital-related cost rests on the recognition that all funds from any source have alternative uses and something is given up (i.e., there is a cost) when one particular use is chosen. Thus, the cost of financing capital assets with equity funds also should be taken into account.

In addition to these costs, capital-related costs include the cost of insurance to protect the assets against loss and property taxes imposed on land or depreciable assets.

These capital-related costs are generated directly by hospital transactions involving the acquisition and financing of capital assets. In order to measure or account for the full cost of producing patient care services, all of these costs must be included along with the hospital's operating costs to arrive at an accurate total. Historically, the extent to which traditional accounting methods and measurement techniques have captured the full cost of capital has always been somewhat controversial. Similar controversy also has surrounded the issue of whether and to what extent each element of capital-related cost should be reimbursed by the major purchasers of hospital care (e.g., Medicare, Medicaid, Blue Cross plans, commercial insurers, etc.).

The capital payment policies of the major payers for hospital care are important for three reasons. First, these policies affect the hospital's ability to recover its full cost of providing services and, therefore, its long-term financial stability. Second, such policies may create incentives for hospitals to over or underinvest in capital assets relative to other productive resources, leading to reduced economic efficiency and higher overall costs for producing services. Finally, capital payment policies may create incentives for hospitals to choose one method of financing capital expenditures over another (e.g., debt over equity), which may lead to financial instability, reduced access to capital financing and higher costs for services over the long term.

Trends in the financing of hospital capital expenditures over the last 40 years reflect the influence of the payment policies adopted by the major purchasers of care as well as other factors such as the growth of public and private health insurance programs, government tax and other policies, and trends in general economic conditions such as inflation. These trends are described in the next section.

B. Financing Hospital Capital Needs--Brief History

The funds needed to acquire capital assets such as land, buildings, and equipment, or to renovate existing buildings and equipment, represent a hospital's "capital needs." As noted above, the capital needs of most economic enterprises are generally met through a combination of debt financing (i.e., borrowing) and equity financing (i.e., retained earnings or the sale of stock). For hospitals, however, philanthropy and government subsidy have also been important sources for meeting capital needs.

Hospitals have not ordinarily been able to generate the earnings necessary to finance their capital needs. Instead, financing for capital purposes has usually come from other sources. For example, until World War II, the major source of hospital capital financing was philanthropy--e.g., donated funds from individuals, religious groups or local community subscription. 2/ After the War, public financing in the form of Federal grants and loans under the Hill-Burton program became an increasingly important additional source of capital financing for hospital plant construction and renovation for many institutions. 3/

2/ It has been estimated that about two-thirds of capital provided the industry before World War II came from philanthropic sources.

3/ Nearly 4,000 hospitals received about $4 billion in grants, while 300 facilities received an additional $1.9 billion in loans and loan guarantees, under the Hill-Burton program before it ceased to exist as a source of capital in the 1970's.

The end of the war also marked the beginning of dramatic growth in private health insurance protection, provided through the workplace, against the costs of hospital care for workers and their dependents. This development was important in the history of capital financing in the hospital sector because the certainty of payments from such sources increased the stability of hospitals' cash flow and ensured that revenues would be available to repay borrowed principal and interest obligations. Thus, increased financial stability enhanced opportunities to use borrowed funds as a source to finance capital needs.

The enactment of Medicare and Medicaid in the mid-1960's also had major effects on the relative importance of different sources of hospital capital financing. First, as with private insurance coverage, Medicare and Medicaid further improved the general financial stability of the hospital industry. Before creation of these two government programs, the elderly and the poor--both important segments of the caseloads of many community hospitals--were often unable to pay for the hospital services they received. Medicare and Medicaid helped to reduce both the free care and bad debt burdens represented by each of these groups for many institutions.

Second, Congress decided to pay for care provided to the aged and poor under these new programs on the basis of the actual costs incurred, not on the basis of the prices charged by the hospitals for such services. This decision to opt for cost-based reimbursement further encouraged borrowing as a source of capital financing because the Government included both depreciation expense and interest expense on borrowed funds in its definition of reimbursable costs. 4/

4/ These and the other capital-related expenses paid for on a cost basis under Medicare are discussed in detail in the next section of this report.

In addition, these developments encouraged lenders to make funds available to hospitals because the certainty of depreciation and interest reimbursement significantly reduced the risk that borrowed funds would not be repaid. Debt financing was also encouraged because cost reimbursement generally reduces a hospital's ability to accumulate net earnings (revenues in excess of costs) from a cost-based payer. This occurs because under cost reimbursement, payments (revenues) to the hospital are set approximately equal to its incurred costs. Thus, efforts to increase retained earnings by lowering costs are met by equal reductions in payments. As a result, the potential to obtain net earnings from cost-based reimbursement is essentially eliminated. Reimbursement of depreciation expense also made borrowing an attractive method of financing capital needs. In the early years of debt repayment, cash inflow for depreciation often exceeds cash outflow for the repayment of principal (known as amortization), thereby generating "excess" funds that can be used for any number of noncapital-related purposes. 5/

Other factors, of course, also contributed to the steadily increasing use of debt as the principal source of funds to meet capital needs for the hospital industry during the last two decades. These included the decline of philanthropic contributions, the development of mortgage loan insurance to facilitate hospital plant and equipment purchases, governmental policies that expanded and encouraged the issuance and use of tax-exempt debt instruments to finance capital needs, and long periods of persistent and sometimes severe inflation. During

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5/ Amortization is the repayment of loan principal on an installment basis. Under a level loan repayment schedule (e.g., constant payment per month over the life of the loan), the amount of the installment payment representing principal is, at the beginning of an amortization period, usually quite small and usually less than the depreciation amounts reimbursed by Medicare during the initial years of repayment of the loan.

periods of rapid inflation, for example, hospitals found that loans could be paid back in the future with dollars cheaper than those that had been borrowed.

The impact of these influences on the sources of capital financing has been dramatic. One estimate for 1962 indicated that only about 12 percent of new hospital plant was financed by borrowing. 6/ By 1969, about 40 percent of the construction costs of nonprofit hospitals and more than 60 percent for investor-owned institutions were financed from debt sources. 7/ Debt is now by far the most important source of capital financing for the hospital industry: 8/

6/ J.B. Silvers, "How Do Limits to Debt Financing Affect Your Hospital's Financial Status?" Hospital Financial Management, February 1975, p. 32.

7/ Irwin Wolkstein, "The Impact of Legislation on Capital Development for Health Facilities," Health Care Capital: Competition and Control. Ballinger Publishing Company, Cambridge, Massachusetts, 1978.

8/ Survey of Sources of Funding for Hospital Construction, American Hospital Association. The hospital industry borrows funds for more than construction. For example, about 60-65 percent of the debt-raised capital in 1981 went for project costs, including construction expenses, equipment acquisitions and architectural and engineering fees. The balance of the borrowings was used to refinance existing debt, for debt service reserves and capitalization of interest funds, and for other purposes.

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Sources of Hospital Construction Funding, 1973-1981

Funding Sources	1973	1977	1981
Government grants & appropriations	20.8%	17.2%	12.1%
Philanthropy	9.9	7.1	3.9
Hospital reserves a/	14.9	13.2	14.9
Debt	54.4	62.5	69.1

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a/ Reserves include funded depreciation, sale of replaced assets and equity for investor-owned hospitals.

II. MEDICARE'S PRESENT CAPITAL PAYMENT RULES

A. General

Present law provides that certain capital-related costs incurred by hospitals in providing inpatient services to Medicare beneficiaries are reimbursable on a reasonable cost basis. Under current law, these costs are excluded from Medicare's prospective payment system for inpatient hospital services until October 1, 1986.

Current regulations define the capital-related costs that the Secretary of Health and Human Services recognizes as allowable for reimbursement purposes. Such costs must be reasonable and related to the provision of patient care. Reasonable costs include all necessary and proper expenses incurred in rendering services to beneficiaries. To be allowed, costs cannot exceed what a prudent and cost-conscious buyer would pay for a given item or service.

Medicare's payments to hospitals for capital-related costs are based on the share of the hospitals' total capital costs that is attributable to services provided to program beneficiaries. Thus, the allowable capital costs of each participating hospital are apportioned or divided between Medicare program beneficiaries and the other patients using the hospital. This is accomplished through accounting methods which measure the use of the hospital's resources by Medicare beneficiaries relative to the total hospital resources used by all patients served. Once Medicare's share is determined, such amounts are paid to the hospital in addition to any payments for inpatient services under the prospective payment system. Other additional payments are made for the costs of medical education, kidney acquisition and services of non-physician anesthetists.

B. Major Elements of Capital Cost Reimbursed by Medicare

Among the major elements of capital cost currently reimbursable under Medicare are: 9/

1. Depreciation. Medicare recognizes depreciation as an element of capital cost payable by the program. Depreciation expenses are amounts which represent the portion of an asset's cost that is charged-off to a particular period of operation, such as an accounting or reporting period (usually a year). In the case of hospitals, depreciable assets include: buildings, building equipment, major movable equipment, minor equipment, land improvements and leasehold improvements made by a lessee. 10/

Depreciation accounting is a system of accounting which prorates the acquisition cost or other basic value of tangible assets, less salvage value (if any), over the "useful lives" of such assets. 11/ The measurement of periodic depreciation expenses or charges is dependent on three factors: the depreciation base, the "useful life" of the asset and the depreciation method.

Under Medicare, depreciation is based upon the "historical cost" of the acquired assets. Historical cost is the cost incurred by the present owner in

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9/ In addition, the regulations define capital-related costs to include a number of other minor items, such as certain betterments and improvements, the costs of minor equipment that are capitalized rather than charged off to expense, some insurance costs of depreciable assets used for patient care, and taxes on land or depreciable assets used for patient care.

10/ Land is not a depreciable asset.

11/ Salvage value is the estimated amount expected to be realized upon sale or other disposition of a depreciable asset at the end of its useful life.

acquiring the assets. The estimated useful life of an asset is its expected useful life to the hospital, not necessarily the asset's inherent useful life or physical life. In general, the estimated useful lives developed by the American Hospital Association (AHA) are used by hospitals and accepted by the Medicare program for determining depreciation. 12/ For assets acquired in 1983 and thereafter, the AHA's Estimated Useful Lives of Depreciable Hospital Assets (1983 edition) is used as a guide for such purposes. An earlier (1978) edition is used for assets acquired in 1982. The AHA's 1973 Chart of Accounts is used in connection with assets acquired before 1982.

Since August 1, 1970, only the "straight-line" depreciation method has generally been allowed for prorating the historical cost of an asset under Medicare. In this method, the historical cost of an asset (minus any salvage value) is charged in equal amounts per year over the useful life of the asset. Thus, a building with a historical cost of $25 million (with no salvage value) and an estimated useful life of 25 years would be depreciated at $1 million per year. Medicare does not require the funding of depreciation; that is, the hospital is not required to set aside cash (in an amount equal to allowed depreciation) for the replacement of depreciated assets, buildings or equipment.

The Economic Recovery Tax Act of 1981 (P.L. 97-34) made a number of changes in the calculation of depreciation for income tax purposes. However, the law excludes Medicare (and other programs administered by the Secretary of Health and Human Services) from the new depreciation rules for purposes of determining cost reimbursement under the program.

12/ For example, the AHA guidelines show a useful life of no more than 40 years for buildings. Fixed assets in the buildings, such as elevators, heating and air conditioning, plumbing, etc., have suggested useful lives of between 10 and 20 years.

2. Rental Expense. Rental expenses including license and royalty fees are recognized by the Medicare program as capital-related costs if these expenses are related to the use of assets that would be depreciable if they were owned by the hospital. Thus, rental expenses for the use of capital assets such as buildings or equipment that are reasonably related to patient care would be allowable capital-related costs. Under certain conditions, however, reasonable and allowable rental expenses may be limited to the amount of capital-related cost (e.g., for depreciation, interest expense and insurance) the hospital would have incurred if it owned the assets instead. This limitation may apply, for example, in certain "sale and lease-back" arrangements or where a rental agreement provides for rental charges that appear excessive given the rental charges for comparable assets in the area.

3. Interest Expense. Necessary and proper interest expense on capital indebtedness is included as an allowable capital-related cost under Medicare. Capital indebtedness represents long-term loans in which the funds are used for meeting capital needs, i.e., acquiring or improving facilities and equipment. Although interest expenses related to short-term borrowing (e.g., for working capital needs) are an allowable cost, they are generally treated as operating costs and, therefore, not included in capital-related costs.

To be recognized as a Medicare allowable cost, interest must be incurred on funds borrowed to satisfy the financial needs of the hospital and must be for a purpose reasonably related to patient care. The rate of interest must not exceed what a prudent borrower would have had to pay in the money market in an arms-length transaction. The interest must be paid to a lender not related through control, ownership, or personal relationship to the borrowing organization.

Generally, allowable interest expenses are offset (i.e., reduced) by investment income, except where such income arises from investment of gifts, grants, endowments, funded depreciation, pension funds, and deferred compensation funds.

4. Return on Equity Capital of Proprietary Hospitals. A specified return on equity (or owner) capital invested and used in providing patient care is an allowable cost for proprietary, or for-profit, hospitals under Medicare. Equity capital is the net worth of a hospital (assets minus liabilities, excluding those assets and liabilities not related to patient care). Specifically, equity capital includes: (1) the net investment in plant, property and equipment (net of accumulated depreciation and long term debt) related to patient care, plus deposited funds required in connection with leases; and (2) net working capital (i.e., cash on hand) maintained for necessary and proper operation of patient care facilities.

The base amount of equity capital used in computing the allowable return is the average investment of the owners during a reporting period. Under current law (P.L. 98-21) the rate of return on the average amount of equity is equal to the average rate of interest paid by the Federal Treasury on the assets of Medicare Hospital Insurance Trust Fund during the same period. Prior to May 1983, the rate of return was one and one-half times the interest rate paid on trust fund assets:

Interest Rates on Medicare Hospital Insurance Trust Fund Assets and Rate of Return on Equity Capital for Inpatient Hospitals

For the Month of:	Interest rate HI Trust Fund* (percent)	Payment Factor	Rate of Return on Equity Capital* (percent)
July 1982	13.875	x 1.5	20.812
October 1982	11.625	x 1.5	17.438
January 1983	10.500	x 1.5	15.750
April 1983	10.625	x 1.5	15.938
July 1983	10.875	x 1.0	10.875
October 1983	11.375	x 1.0	11.375
January 1984	11.500	x 1.0	11.500
April 1984	12.375	x 1.0	12.375
July 1984	13.750	x 1.0	13.750
October 1984	12.375	x 1.0	12.375
January 1985	11.500	x 1.0	11.500
April 1985	11.625	x 1.0	11.625
July 1985	10.250	x 1.0	10.250
October 1985	10.375	x 1.0	10.375
January 1986	9.125	x 1.0	9.125

* Annualized rate

The amount of the allowable return on equity (ROE) is computed as the product of the average amount of equity capital and the average rate of return during the reporting period. If the average equity during the period was $10 million, and the average rate of return was 12 percent, the allowable return would be $10 million x .12 or $1.2 million. Medicare's payment to the hospital is determined by the share of the hospital's total costs that is attributable to Medicare. Thus, if Medicare inpatient costs accounted for 40 percent of the hospital's total allowable costs, then Medicare's payment for return on equity related to inpatient services in this example would be $1.2 million times .4 or $480,000.

C. Future Payment of Hospital Capital-Related Costs

Public Law 98-21, the Social Security Amendments of 1983, directs the Secretary of Health and Human Services to study and report to Congress on methods and proposals under which capital-related costs, including a return on equity, may be included in the prospective payment system. This report, which was due in October 1984, has not been submitted.

P.L. 98-21 also provides that, if legislation regarding inclusion of capital-related costs under the prospective payment system is not enacted by Congress prior to October 1, 1986, Medicare payment cannot be made for capital costs unless a State has a capital expenditure review agreement with the Secretary of HHS (under Section 1122 of the Social Security Act) and the State has recommended approval of the expenditure. The conference report on P.L. 98-21 also expresses the intent of Congress that, if the Secretary has implemented a system of prospective payments for capital-related costs (without any further action by Congress) and the mandatory Section 1122 approval process goes into effect, the Secretary must make adjustments to the payment rates to reflect capital-related costs not approved under Section 1122.

P.L. 98-21 also includes a provision expressing the intent of Congress that, when including capital-related costs under the prospective payment system, new capital projects for which expenditures are made on or after October 1, 1983 may be reimbursed differently from projects begun before that date. In other words, no assurances are given that obligations incurred after that date will be reimbursable on a reasonable cost basis.

Uncertainty about future payment policy regarding capital-related costs is cause for concern on the part of hospitals that have recently begun or completed large capital projects, hospitals that anticipate undertaking such projects in the near future, and the financial institutions involved in financing hospital capital projects. The reasons for this concern and the major issues related to the development of a new policy regarding payments for capital-related costs are explored in the next section.

III. ISSUES IN DESIGNING A NEW CAPITAL PAYMENT POLICY

In adopting a prospective payment system for hospitals under Medicare, Congress sought to establish effective financial incentives (including both rewards and penalties) to control spending in the provision of inpatient services to beneficiaries. Although Congress excluded capital-related costs from the prospective payment system, the provisions of P.L. 98-21 cited above clearly indicate the congressional desire to include such costs as soon as feasible methods could be found.

Medicare capital-related costs, however, represent only a small fraction of hospital costs currently subject to the prospective payment system. For example, during fiscal year 1984, estimated Medicare hospital inpatient operating costs amounted to about $36.0 billion. Estimated Medicare hospital capital-related costs in the same year amounted to only about $2.9 billion: $1.6 billion (55 percent) for depreciation of fixed assets, $0.4 billion (14 percent) for depreciation of moveable assets $0.7 billion (24 percent) for interest costs and $0.2 billion (7 percent) for return on equity. 13/ Thus, reimbursable capital-related costs represent only about 8.1 percent of total Medicare hospital spending (operating costs) already subject to prospective payment.

Nevertheless, potential alternative capital payment policies under prospective payment have become a topic of considerable discussion and debate, despite

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13/ Rental expenses and other minor elements of capital-related costs are not separately identifiable in the cost reports submitted annually by hospitals to the Medicare program. These amounts are generally included with the reported depreciation expense figures.

the relatively small percentage of funds actually expended by Medicare for such purposes. The purpose of this section is to describe the main reasons for this interest and the issues related to the design of a new payment policy for hospital capital costs under Medicare.

A. Reasons for Interest in Medicare Capital Payment Policy

The Congress, the Reagan Administration, various groups within the hospital industry and others have expressed strong interest in the development of new capital payment policies under Medicare. The reasons for this interest are many and varied. First, a number of analysts have expressed concern about the impact that current policy (cost reimbursement) may have on the financial incentives faced by hospital managers in economic decisionmaking. These analysts have argued that cost reimbursement for capital costs coupled with prospective payment for operating costs may create a variety of potentially undesirable incentives including:

--The incentive to substitute capital assets for other resources such as labor. For example, if the purchase of a new information processing system would reduce the hospital's need for clerical staff and thereby lower its operating costs, the hospital would have a strong incentive to make the purchase, even if its total costs (operating costs plus capital costs) would be increased as a result.

--The incentive to finance capital purchases by borrowing. This incentive arises for three reasons. First, Medicare's share of the hospital's net interest expense (after interest earnings are offset against interest expenses) is fully reimbursed. Second, in an inflationary period, depreciation based on historical cost generally does not allow the hospital to recover the full replacement cost of its assets. By the time an asset is fully depreciated (the historical cost is recovered), the price of a replacement asset has generally increased substantially. Thus, the hospital's real (inflation adjusted) equity capital is diminished since it recovers less in depreciation payments than would be needed to maintain the same real value of assets over time. Finally, the cost of equity capital is not reimbursed (except in the case of proprietary hospitals).

In addition, these analysts have noted that cost reimbursement permits hospital managers to ignore prevailing market conditions in deciding on the timing of their investment projects. Thus, the hospital administrator whose interest expenses are reimbursed on a cost basis may not need to postpone a major capital expenditure even though interest rates are unusually high. Some analysts have also noted that, under current policy, the Medicare program implicitly subsidizes the capital costs of underutilized hospitals. This occurs because Medicare pays a share of the hospital's total capital costs that is based on the share of total resources consumed by program beneficiaries. Thus, if Medicare's share of hospital resources is 40 percent, the program pays 40 percent of the hospital's total allowable capital costs regardless of whether the hospital operates at 20 percent or 95 percent of its capacity.

Many observers expect these features of current capital payment policy to lead to higher capital costs and higher overall costs for inpatient services than would otherwise occur. It is also important to note, however, that the Medicare program is not the only purchaser of hospital inpatient services. Thus, the strength of these effects may be diminished to the extent that the payment policies of other major payers create off-setting or conflicting incentives.

A second reason for interest in capital payment policy derives from concern about the potential effects of alternative policy options on hospitals' access to capital financing in the future. Many observers have expressed concern that hospitals facing increased competition in the marketplace may experience greater difficulty in obtaining the financing they need if Medicare capital policy becomes more restrictive. These observers argue that a restrictive capital policy under Medicare could lead to deterioration in the quality of services provided not only to Medicare patients but to all patients.

These concerns have been expressed especially with regard to rural hospitals and large urban public hospitals which traditionally have had difficulty in obtaining access to capital financing.

Another reason for concern is related to variations in the relative importance of capital costs across hospitals. Although estimated total reimbursable capital-related costs represent on average only about 7.5 percent of total (rather than operating) hospital costs under Medicare, many hospitals have a much greater than average proportion of capital-related costs in some years, while others have a lower than average proportion of capital-related costs. Capital costs, in other words, are unevenly distributed among the hospitals participating in the Medicare program. This is largely due to the fact that major capital expenditures--especially for replacing, modernizing, or adding new buildings and fixed equipment--occur infrequently. Hospitals that have just completed large capital projects may, in any one year, have capital costs amounting to well over 20 percent of their total expenses. Older facilities, on the other hand, can have capital costs amounting to 4 percent or less of their current total expenses. This variation is well illustrated by the distribution of Medicare capital costs to total Medicare hospital costs across hospitals in 1981: 14/

14/ Gerard Anderson, from a presentation to the Advisory Committee on Social Security; reprinted in "Including Capital in Prospective Payment: Questions and Information Pertinent Thereto," Catholic Hospital Association, October 1983. Data exclude return on equity amounts.

Medicare Capital Costs, As a Percentage of
Total Medicare Hospital Costs, 1981

Capital costs/Total costs	Percentage of Hospitals
Less than 4%	25.3%
4% to 6.6%	34.6
6.6% to 10%	22.2
10% to %15	12.6
15% to 20%	3.5
More than 20%	1.9
Mean percentage (all hospitals)	6.6%

As these data suggest, the short-term impact of alternative capital policies under prospective payment may be very different for hospitals in different circumstances.

These concerns raise important issues for the design of a new capital payment policy under Medicare. These issues are discussed briefly in the next section.

B. Major Issues in Capital Payment Policy Design

In general, there are four major issues related to the design and impact of a new Medicare capital payment policy. They are: (1) the basis of payments for capital-related costs, (2) the level of payments for such costs, (3) the nature and duration of a transition policy to ease the change from the old to the new payment method, and (4) the nature of any adjustments and exceptions provided to allow for factors that may affect capital costs but are beyond the hospital's control. These issues are discussed below:

1. The Basis of Capital-Related Payments. Payments for capital-related costs could be based on each hospital's actual incurred costs (continuing current policy), or they could be set on a prospective basis, for example, to

reflect the average experience of hospitals in a peer group (e.g., national, regional or urban and rural averages). The key issue here is whether and to what extent the payments received by a hospital can be influenced by changes in the hospital's behavior. If payments are based on incurred costs, then the hospital's payments are determined by its decisions regarding which capital investment projects to undertake and how to finance them. On the other hand, if capital payments were based on a prospectively determined rate (e.g., a fixed amount per discharge set in advance), then payments would be largely outside the hospital's control. In this case, the payments received by the hospital would be determined by the payment rate and the volume of Medicare discharges regardless of any capital investment decisions it made.

Payment of capital costs on a prospective basis generally would reverse many of the financial incentives faced by hospitals under current policy. Prospective payment per discharge for capital costs coupled with the current system of prospective payment for operating costs would eliminate the financial incentive to favor capital assets relative to other resources. Instead, hospital managers would have incentives to minimize the total cost of delivering services to Medicare beneficiaries. The financial incentives also would be neutral regarding the method of financing needed capital investments. Hospitals would have an incentive to adopt the combination of financing methods (e.g., debt versus equity, short term versus long term debt instruments, etc.), that minimized the costs of obtaining the required capital. Payment for capital costs on the basis of a prospective rate per discharge also would eliminate the possibility that the Medicare program could subsidize the capital costs of a hospital operating at only a small fraction of its capacity. This possibility would be eliminated because payments for capital would be tied to the volume of Medicare discharges rather than to Medicare's share of total hospital utilization.

It should be noted here that these advantages would exist regardless of whether the prospective rate per discharge for capital costs was held separate from, or combined with the existing prospective payment rates for operating costs. These advantages derive from the fact that the hospital under full prospective payment cannot change its capital payment or its total payment per discharge (capital plus operating) by changing its investment decisions. Instead, in order to increase profits (or reduce potential losses), the hospital manager can only reduce the actual total cost per discharge incurred in providing services to patients.

Prospective rates as a basis for capital payments, however, also have some disadvantages. First, payment on this basis would penalize hospitals which have recently completed or are about to begin large investment projects. For example, a prospective capital payment rate per discharge, set to cover the average capital cost per discharge in all hospitals, generally would fall far short of the actual cost per discharge experienced by a hospital that has recently replaced its buildings and fixed equipment. Similarly, an average rate would not be adequate to cover the capital costs anticipated by a hospital that is about to begin a major project. It is likely that such a hospital would have to postpone a major project until surplus revenues could be accumulated to cover the high initial capital costs.

Second, prospective payment for capital costs in conjunction with prospective payment for operating costs may increase the strength of some generally undesirable incentives such as the incentive to increase admissions of relatively healthy Medicare patients while avoiding admission of severely ill patients or the incentive to describe cases as though they belong to a higher paid DRG (DRG-creep). It should be noted, however, that the proportion of the hospital's costs subject to prospective payment would not increase very much as a result of including capital costs. Thus, the potential change in the strength of these incentives might not be very substantial either.

Of course, capital costs need not be paid entirely on one basis or the other. Some analysts have suggested, for example, that the capital costs attibutable to buildings and fixed equipment could continue to be paid on an incurred cost basis while the costs of moveable equipment could be paid according to a prospective rate. The main rationale for this approach is that buildings and fixed equipment represent very expensive and relatively long-lived assets which tend to be replaced only at long intervals. Thus, these assets may have a very pronounced investment cycle of high initial capital costs followed by long periods of declining costs. Moveable assets, which tend to be less expensive and relatively short-lived, may be replaced much more often with the result that the associated capital costs may fluctuate much less from year to year.

Such a mixed system would result in mixed financial incentives too. Thus, for example, hospitals would have an incentive to minimize the costs of all resources except fixed assets. To the extent that buildings or fixed equipment could be substituted for other resources, the hospital would have an incentive to do so even though total costs were increased. For example, renovation of the hospital's main building to make more efficient use of existing space and reduce internal traffic flow could reduce operating costs but increase total costs.

2. The Level of Payment. If capital costs are paid on a prospective basis, then the question of how to set the level of capital-related payments would need to be examined. The level of the payment rates will generally depend on three factors: (1) which elements of capital costs are included in the capital cost base used to calculate the rates, (2) the nature of the update

factors used to adjust the base amount for inflation between the base period and the year in which payment is to be made, and (3) the nature of any adjustments to the base amount.

These issues could be resolved in many different ways. For example, various proposals have suggested that only capital costs historically recognized nized by the Medicare program should be included in calculating the base capital cost amount. Others have suggested that the return on equity capital paid to for-profit hospitals should be excluded from the base. In addition, some have argued that interest earnings from all sources (including earnings from investment of funded depreciation, gifts and grants, pension funds and deferred compensation funds) should be offset against allowable interest expenses in determining base year capital costs. By contrast, others have argued that the base should include not only historical payments for return on equity for proprietary hospitals, but a return on equity for non-profit and publicly owned hospitals as well.

Issues regarding the nature of the update factors used to adjust the base year amount to the year of payment have a similar range of possibilities. For example, update factors could be based only on proxy measures of changes in the cost of capital, or they could incorporate trends in capital expenditures and in the volume of hospital discharges between the base year and the payment year. Thus, recent increases in the volume of capital expenditures have tended to increase the level of capital costs per discharge and recent declines in the volume of discharges also have tended to increase the level of costs per discharge as the same costs are spread over fewer discharges.

A number of other adjustments to the base amount also could be made. Some analysts, for example, have suggested adjustments to the base amounts for low occupancy hospitals to remove the historical capital cost subsidies paid under cost reimbursement. Other analysts have argued that the aggregate level of capital payments should be adjusted (after updating for inflation) to be budget neutral to the amount that would have been paid if current policy had continued. As noted above, however, different proposals have suggested both higher and lower amounts.

3. Transition Policy. The nature and duration of any transition mechanism is an important issue that has received much attention. Generally, proposed transition mechanisms are designed to avoid or reduce the penalties that would otherwise be imposed on hospitals that have recently completed major capital projects. Most such mechanisms combine a hospital-specific payment rate which reflects the current capital costs of the hospital with a national average or other target rate which reflects the capital payment rate that will apply after the transition period has ended. These rates are initially combined so that the blended rate is mostly based on the hospital-specific component. As the transition period proceeds, however, the blended rate shifts toward the target rate and ultimately, the blended rate becomes equal to the target rate.

Transition periods ranging from 5 years up to as much as 18-20 years have been suggested. Naturally, the longer the period, the lower the potential penalties would be for hospitals that currently have high capital costs. However, hospitals in need of major renovation or replacement in the near future would tend to be penalized instead. This would occur because these hospitals tend to have below average capital costs. Thus, their blended rate in the early years of the transition would tend to be below average. For these hospitals, the longer the transition period, the longer they have to wait until their capital payment rates would approach the average payment rate.

One potential solution to this dilemma may be to periodically recalculate the hospital-specific portion of the blended payment rate based on the hospital's actual costs (e.g., every year or every other year). Under this approach, a hospital needing to make a major investment very early in the transition period could do so without being badly penalized (although the penalty would not be eliminated). The disadvantage to this approach for some observers is that it would require continued use of cost reports and other administratively burdensome methods in order to allow for periodic recalculation of each hospital's actual capital costs.

4. Adjustments and Exceptions Policy. The final major issue relates to choices regarding a number of potential adjustments which could be incorporated in the calculation of prospective capital payment rates. Most of these adjustments would modify the payment rates to some extent to allow for differences in individual hospital circumstances. Some analysts, for example, have suggested that capital costs may vary substantially across DRG categories. These analysts contend that if such differences are ignored, then the payment system as a whole will encourage hospitals to avoid some types of cases (those with above-average capital costs), while trying to attract patients in other categories (those with below-average capital costs). Other analysts, however, have noted that while variations in capital costs across DRG categories may exist, they have not been well documented. Moreover, the traditional accounting methods used to allocate capital costs assign those costs to hospital service departments rather than to the individual services typically used in each DRG. Thus, the available historical data are probably much too crude to reveal differences in capital costs among DRGs even when they are quite substantial.

A second type of rate adjustment considered in some proposals would adjust the payment rates to reflect variations in capital costs across regions or local market areas. Construction costs, for example, almost certainly vary from one market area to another in response to variations in local wage scales, transportation costs for key materials, and other factors. The data available for measuring such variations, particularly at the local market level, however, are somewhat limited.

Other potential adjustments raise difficult policy issues. For example, should Medicare capital payments be adjusted for certain segments of the hospital industry which have difficulty in raising capital? Some analysts have noted that a major portion of the hospital industry including small rural hospitals and financially troubled urban hospitals has traditionally had great difficulty in obtaining access to debt capital. When they are able to obtain financing, these hospitals generally incur above average costs for capital because of the risk premium demanded by lenders. As a result, a prospective payment for capital costs based on the average cost of capital may not be adequate for hospitals in these circumstances.

Some of these issues could be addressed by allowing exceptions or individual payment adjustments for extraordinary circumstances instead of relying on automatic payment adjustments. Although exceptions policies may be difficult or costly to administer, some analysts believe such policies may have important benefits where the effects of local conditions and special circumstances cannot be systematically incorporated in the payment system.

Five recent proposals to include payments for capital-related costs in the prospective payment system are described in the next section.

IV. RECENT LEGISLATIVE AND REGULATORY PROPOSALS

Three bills introduced in the 99th Congress would amend Section 1886 of the Social Security Act to incorporate payments for capital-related costs under Medicare's prospective payment system (PPS):

- S. 1346 (Kennedy) and H.R. 1801 (Gephardt), The Medicare Solvency and Health Care Financing Reform Act of 1985.
- S. 1559 (Durenberger/Quayle), The Medicare Capital Payment Reform Act of 1985.
- S. 2121 (Durenberger/Quayle), The Fair Deal Capital Payment Act of 1986.

In addition, the President's fiscal year 1987 Budget indicates that the Administration plans to include payments for capital-related costs in DRG payments under PPS starting with hospital cost reporting periods beginning during fiscal year 1987. This proposal would be implemented through PPS regulations to be published later this year.

Finally, the Prospective Payment Assessment Commission (ProPAC) recently approved a series of recommendations regarding methods of payment for capital-related costs under PPS. These recommendations will be included in ProPAC's annual report advising the Secretary of HHS about changes to PPS. The report is due by April 1, 1986.

The provisions of these proposals are briefly summarized below. In order to facilitate comparisons among the proposals, the description of each plan is organized to follow the outline of design issues presented in Section III.B.

above. Thus, the description of each proposal is divided into sections that focus on: (1) the proposed method of payment; (2) how the level of payment for capital-related costs would be determined; (3) the nature of the proposed transition schedule; (4) proposed rate adjustments and exceptions; and (5) additional provisions.

A. S. 1346 (Kennedy) and H.R. 1801 (Gephardt), The Medicare Solvency and Health Care Financing Reform Act of 1985

Effective on January 1, 1986, this bill would establish a 2-year transitional Federal hospital prospective payment system based on DRGs for all private payers (excluding Medicare and Medicaid). States would be encouraged to develop their own cost containment plans that meet certain Federal requirements. Hospitals in States with plans approved by the Secretary of HHS would be exempt from the Federal plan, while hospitals in States without approved plans in effect after 2 years would be subject to a stricter Federal all-payer hospital rate-setting plan. The bill also contains provisions amending the current prospective payment system under Medicare to include physician costs and capital-related costs.

Under the capital-related provisions of this bill, the Secretary of HHS would be required to establish a separate DRG-specific prospective payment rate per discharge for making payments to PPS hospitals for capital-related costs. This provision would be effective for hospital cost reporting periods beginning on or after January 1, 1986. The current method of capital payments based on incurred costs (pass-through payments) would be discontinued for PPS hospitals (but not for PPS-exempt hospitals).

Method of Payment

The capital-related rate per discharge for any DRG would be determined by multiplying:

(1) an updated capital-related base amount, determined by calculating an updated national average standardized capital-related payment amount per discharge during a base period; times

(2) a capital-related DRG weighting factor, determined for each diagnosis related group by calculating the relative capital-related resources used in that DRG compared to all other DRGs.

Payment Level

- Base period.--Hospital cost report data from PPS hospitals for cost reporting periods ending during the 5-year period ending with fiscal year 1984 would be used as the base for calculating the capital-related base amount.

- Update factor.--The capital-related base amount would be updated to the year in which payments are made by the PPS update factor (which is currently determined at the discretion of the Secretary of HHS).

- Return on equity exclusion.--Payments to proprietary hospitals for return on equity capital would be excluded from the base amount and explicitly prohibited.

Transition

This bill does not provide for a transition mechanism. The bill, however, does allow for exceptions to be made for individual hospitals under certain conditions (see below).

Adjustments and Exceptions

- Urban/rural distinction.--The capital-related base amount would not be calculated separately for urban and rural hospitals.

- Regional construction cost adjustment.--The updated capital-related base amount would be adjusted to account for the effects of regional differences in construction costs. This adjustment would apply to the proportion of the capital-related base amount that is attributable to construction-related costs.

- DRG adjustment.--The capital-related base amount would be adjusted to remove the effects of differences in case mix (the mix of Medicare cases among the DRGs) across hospitals. Since the capital-related payment amount per discharge in any DRG would be calculated by multiplying the updated base amount times a separate capital-related DRG weighting factor, payment amounts would be automatically adjusted for differences in the use of capital-related resources across DRGs.

- Volume adjustment.--Capital-related payment rates for admissions in excess of the hospital's base year admission volume would be paid at 40 percent of the normal rate (50 percent for hospitals in States with an approved State plan).

- Indirect teaching adjustment.--This bill does not address the question of whether the adjustment for indirect costs of medical education would apply to payments for capital-related costs.

- Exceptions.--If a hospital could demonstrate that its capital-related payments under this new method would be significantly less than the amount needed to pay interest, principal, and lease payments for a capital project obligated before January 1, 1986 (or approved with a certificate of need filed before February 9, 1984), the Secretary would be required to make additional capital-related payments to the hospital. However, total capital-related payments to the hospital including such additional payments could not exceed the total financial requirements of the project.

Additional Features

- DRG Weighting factor update.--The capital-related DRG weighting factors would be adjusted at least every 4 years to reflect changes in DRG classifications and to take into account factors which may change the relative use of capital-related resources among DRG categories. The Prospective Payment Assessment Commission would be required to consult with and make recommendations to the Secretary on the need for adjustments to the capital-related weighting factors, based on its evaluation of scientific evidence with respect to new medical practices and new technology. The Commission also would be required to report to Congress on its evaluation.

B. S. 1559 (Durenberger/Quayle), The Medicare Capital Payment Reform Act of 1985

Effective for discharges occurring on or after October 1, 1986, the Secretary of HHS would be required to adjust each hospital's national DRG payment rates to include an add-on payment for capital-related costs. The current method of capital payments based on incurred costs (pass-through payments) would be discontinued for PPS hsopitals (but not for PPS-exempt hospitals).

Method of Payment

The capital-related add-on payment would be determined by multiplying:

(1) the national DRG rate for Medicare discharges within each of the diagnosis related groups; times

(2) an add-on ratio. The add-on ratio would be based on the ratio of Medicare payments for capital-related costs to Medicare payments for operating costs in a base period. Thus, a hospital's prospective payment rates for operating costs would be increased to cover both operating and capital-related costs.

During a transition period, the add-on ratio would change from a ratio based primarily on the hospital's historical relationship between payments for capital and payments for operating costs, to one based primarily on the national average historical relationship between payments for capital and payments for operating costs. Thus, each hospital's add-on ratio would combine two ratios:

(1) a hospital-specific ratio of Medicare payments for capital-related costs to Medicare payments for operating costs during a base period; and

(2) a national average ratio of Medicare payments for capital-related costs to Medicare payments for operating costs for all PPS hospitals in the base period.

At the conclusion of the transition period, the capital-related add-on ratio would be based entirely on the national average ratio.

Payment Level

- Base period.--Hospital cost report data from PPS hospitals for cost reporting periods ending during the 3-year period ending with fiscal year 1986 would be used as the base for calculating the national and hospital-specific ratios. If a hospital was not in operation for all 3 years, the base period would be all of the complete fiscal years during which the hospital was in operation before fiscal year 1987.

- Update factor.--Because the add-on amount is determined by multiplying the add-on ratio by the DRG rates, the add-on amount automatically would be updated by the PPS update factor.

- Return on equity exclusion.--The national add-on ratio would exclude payments to proprietary hospitals for a return on equity capital. The hospital-specific ratio would include those payments. As a result, payments for a return on equity would be phased out over the transition period.

Transition

The proportions used to blend the hospital-specific add-on ratio with the national add-on ratio during the transition period would be as follows:

Fiscal year	Hospital-specific add-on ratio	National add-on ratio
1987	.95	.05
1988	.85	.15
1989	.70	.30
1990	.50	.50
1991	.25	.75
1992	---	1.00

In the sixth year (fiscal year 1992) and thereafter, the add-on ratio would be based entirely on the national average ratio of payments for capital-related costs to payments for operating costs.

Adjustments and Exceptions

- Urban/rural distinction.--This bill does not provide for separate add-on ratios for urban and rural hospitals. However, because their DRG payment rates differ, urban and rural hospitals would receive different capital-related payment amounts.

- Construction cost adjustments.--This bill does not provide for adjustments for variations in construction costs across areas.

- DRG adjustment.--This bill does not establish a separate capital-related DRG weighting factor to account for variations in capital costs among DRG categories. Thus, the bill assumes that capital-related costs represent the same proportion of operating costs in each DRG category.

- Indirect teaching adjustment.--This bill does not address the question of whether the adjustment for indirect costs of medical education would apply to payments for capital-related costs.

- Exceptions.--This bill does not provide for exceptions for special circumstances.

Additional Features

- Section 1122.--The bill would repeal Section 1122 of the Social Security Act. Section 1122 authorizes a voluntary program that permits States to enter into agreements with the Secretary of HHS to disallow Medicare reimbursements of capital costs associated with capital expenditures not approved by the States' designated planning agency.

- New hospitals.--Capital-related payments to new hospitals (i.e., hospitals that were not in operation for an entire year before fiscal year 1987) would be based solely on the national add-on ratio with no hospital-specific proportion, even during the transition period.

- Use of estimates.--The Secretary of HHS would be permitted, to the extent necessary, to use estimates of costs and payments in determining capital-related add-on ratios. The Secretary would be required to adjust the estimates as new data become available and to adjust payments to hospitals accordingly.

- Reports to Congress.--The Secretary of HHS would be required to report to Congress on the appropriateness of the add-on amount for capital-related costs whenever adjustments to the DRG classifications and weighting factors are made. The HHS Secretary is currently required to make such adjustments at least every 4 years.

C. S. 2121 (Durenberger/Quayle), The Fair Deal Capital Payment Act of 1986

Effective for fiscal years beginning on or after October 1, 1986, the Secretary of HHS would be required to include payments for capital-related costs along with payments for operating costs in a single DRG payment rate. The current method of capital payments based on incurred costs (pass-through payments) would be discontinued for PPS hospitals (but not for PPS-exempt hospitals).

Method of Payment

The hospital's overall PPS payment amount per discharge (before it is multiplied by the DRG weight) would be determined by adding:

(1) an updated national average standardized capital-related payment amount per discharge; to

(2) the nonlabor component of the PPS payment amount for operating costs.

During a transition period, a hospital's Medicare capital-related payment amount per discharge would change from an amount based primarily on the hospital's actual incurred capital-related cost per discharge, to an amount based primarily on an updated national average standardized capital-related cost per discharge. The hospital's capital-related payment amount per discharge in each DRG during this period would be composed of portions of:

(1) a hospital-specific amount equal to the average capital cost per discharge incurred during the fiscal year by the hospital as calculated under current Medicare reimburesement principles; and

(2) a Federal amount per discharge, multiplied by the DRG weighting factor for the DRG. This amount would be the national average

standardized capital-related cost per discharge incurred by all PPS hospitals in a base year, updated and adjusted for case mix and for local differences in construction costs.

At the conclusion of the transition period, the capital-related payment amount would be based entirely on the Federal amount.

Payment Level

- Base period.--Hospital cost report data from PPS hospitals for the most recent fiscal year for which adequate national data are available would be used ~~as a~~ base for calculating the Federal capital-related amount.

- Update factor.--From the base year until the end of the capital transition period (fiscal year 1993), the Federal portion of the capital-related payment amount would be updated to the year in which payments are made by a capital marketbasket inflation factor determined to be appropriate by the HHS Secretary. For fiscal year 1994 and thereafter, the payment amount would be updated by the PPS update factor.

- Return on equity exclusion.--The Federal amount would exclude payments to proprietary hospitals for return on equity capital. The hospital-specific amount would include such payments. As a result, separate payments for return on equity would be phased out over the transition period.

- Interest expenses exclusion.--Interest expenses, otherwise allowable during the base year, would be offset (reduced) by interest income from any source in calculating the Federal base amount per discharge. Thus, interest income from investment of funded depreciation, grants and gifts and certain other funds (which are currently excluded from the interest offset requirement) would be offset against base year interest expenses. The hospital-specific amount would be calculated under current rules, without this additional interest offset. As a result, net interest expense would be reduced (as would the overall capital-related payment amount) over the transition period.

Transition

The proportions applied to the hospital-specific amount per discharge and to the Federal amount per discharge during the transition period would be as follows:

Fiscal year	Hospital-specific proportion	Federal proportion
1987	.95	.05
1988	.90	.10
1989	.80	.20
1990	.65	.35
1991	.50	.50
1992	.30	.70
1993	.10	.90
1994	---	1.00

In the eighth year (fiscal year 1994) and thereafter, the capital-related payment amount would be based entirely on the Federal capital-related amount per discharge.

Adjustments and Exceptions

- Urban/rural distinction.--This bill does not provide for separate urban and rural capital-related Federal base amounts. However, urban and rural hospitals would receive different amounts of capital-related payments due to other adjustments.

- Local construction cost adjustment.--The Federal capital-related payment amount per discharge would be adjusted for local differences in construction costs.

- DRG adjustment.--This bill does not establish a separate capital-related DRG weighting factor to account for variations in capital costs among DRG categories. Thus, the bill assumes that capital-related costs represent the same proportion of operating costs in each DRG category.

- Indirect teaching adjustment.--This bill does not address the question of whether the adjustment for indirect costs of medical education would apply to payments for capital-related costs.

- Exceptions.--This bill does not provide for exceptions for special circumstances.

Additional Features

- Section 1122.--The bill would repeal Section 1122 of the Social Security Act. Section 1122 authorizes a voluntary program that permits States to enter into agreements with the Secretary of HHS to disallow Medicare reimbursements of capital costs associated with capital expenditures not approved by the State's designated planning agency.

- New hospitals.--Capital-related payments to new hospitals (i.e., hospitals that were not in operation for an entire year before fiscal year 1987) would be based on the payment blend for the first complete fiscal year during which the hospital is operational.

- Use of estimates.--The Secretary of HHS would be permitted, to the extent necessary, to use estimates of costs and payments in determining capital-related payment amounts. The Secretary would be required to adjust the estimates as new data become available and to adjust payments to hospitals accordingly.

D. The Administration's Proposed Regulatory Initiative

Under a proposal in the President's fiscal year 1987 Budget, the Secretary of HHS would include payments for capital-related costs along with payments for operating costs in a single DRG payment rate starting with hospital cost reporting periods beginning on or after October 1, 1986. 16/ The current method of capital payments based on incurred costs (pass-through payments) would be discontinued for PPS hospitals (but not for PPS-exempt hospitals).

Method of Payment

The hospital's overall PPS payment amount per discharge (before it is multiplied by the DRG weight) would be determined by adding:

(1) an updated national average standardized (urban or rural) capital-related payment amount per discharge; to

(2) the nonlabor component of the PPS (urban or rural) payment amount for operating costs.

During a transition period, a hospital's Medicare capital-related payment amount per discharge would change from an amount based primarily on the hospital's incurred capital-related cost per discharge, to an amount based primarily on an updated national average standardized capital-related cost per discharge. The hospital capital-related payment amount per discharge in each DRG during this period would be composed of portions of:

(1) a hospital-specific amount; and

(2) a national (urban or rural) amount per discharge, multiplied by the DRG weighting factor for the DRG.

The hospital-specific amount per discharge would be the lesser of: (a) the hospital's updated capital-related cost in a base year; or (b) the hospital's incurred capital-related cost for each transition year. The hospital's updated capital-related base amount (item (a) above), would include two components: (i) the hospital's depreciation and interest expense including offset of interest income from funded depreciation and charitable contributions, and excluding return on equity; and (ii) return on equity plus the interest income

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16/ This description is based on fiscal year 1987 Budget documents and the testimony of Robert Helms, Acting Assistant Secretary for Planning and Evaluation, before the Subcommittee on Health of the House Committee on Ways and Means on February 24, 1986.

offset amount (for the same items). During the transition period, the return on equity and interest income offset component (ROE/IO) of the hospital's updated capital-related base cost would be subject to a separate phase-out over 3 years.

The national urban and rural amounts would be determined by the national average standardized capital-related cost per discharge incurred by all urban or all rural PPS hospitals in a base year, updated to the year in which payments are made.

At the conclusion of the transition period, the capital-related payment rate would be based entirely on the updated national amount.

Payment Level

- Base period.--Hospital data from 1983 cost reports would be used as a base for calculating the national urban and rural capital-related base amounts. Hospital data from 1986 cost reports would be used as a base for calculating the hospital-specific capital-related base amount.

- Update factor.--The national payment amounts would be updated from 1983 to fiscal year 1986 by the fiscal year 1984, 1985, and 1986 capital marketbasket indexes. For fiscal year 1987 and thereafter, the national payment amounts would be updated by the PPS update factor. The hospital-specific base amounts would be updated by the capital marketbasket index throughout the transition period.

- Return on equity exclusion.--The national amounts would exclude payments to proprietary hospitals for a return on equity capital. The hospital-specific amount would include those payments subject to a separate 3-year phase-out. As a result, separate payments for return on equity would be phased out over the transition period.

- Interest offsets exclusion.--The national amounts would include net interest expenses after offset by interest income from funded depreciation and charitable contributions (in addition to the types of interest income currently required to be offset). The hospital-specific amount would include interest expenses without these additional offsets. As a result, net interest expense would be reduced (as would the overall capital-related payment amount) over the transition period.

Transition

The proportions applied to the hospital-specific amount per discharge, and to the updated national average amount per discharge during the transition period would be as follows:

Fiscal year	Hospital-specific amount	National amount
1987	.80 (including .75 ROE/IO)	.20
1988	.60 (including .50 ROE/IO)	.40
1989	.40 (including .25 ROE/IO)	.60
1990	.20	.80
1991	---	1.00

In the fifth year (fiscal year 1991) and thereafter, the capital-related payment amount would be based entirely on the national amount.

Adjustments and Exceptions

- Urban/rural distinction.--This proposal provides for separate urban and rural national amounts.

- Construction cost adjustment.-This proposal does not provide for adjustments for variations in construction costs across areas.

- DRG adjustment.--This bill does not establish a separate capital-related DRG weighting factor to account for variations in capital costs among DRG categories. Thus, the proposal assumes that capital-related costs represent the same proportion of operating costs for each DRG.

- Indirect teaching adjustment.--This bill does not address the question of whether the adjustment for indirect costs of medical education would apply to payments for capital-related costs.

- Exceptions.--This proposal does not provide for exceptions for special circumstances.

Additional Features

- Section 1122.--The Administration has indicated, in materials accompanying the President's fiscal year 1987 budget, that it supports the repeal of Section 1122 of the Social Security Act. Section 1122 authorizes a voluntary program that permits States to enter into agreements with the Secretary of HHS to disallow Medicare reimbursements of capital costs associated with capital expenditures not approved by the State's designated planning agency. However, the Administration has not included a proposal to repeal Section 1122 in the fiscal year 1987 budget.

E. The Prospective Payment Assessment Commission's Recommendations

Under recommendations approved by the Prospective Payment Assessment Commission (ProPAC), the Secretary of HHS would include payments for capital-related costs along with payments for operating costs in a single DRG payment rate. 17/ This proposal would take effect for hospital cost reporting periods beginning in fiscal year 1987. The current method of capital payments based on incurred costs (pass-through payments) would be discontinued for PPS hospitals (but not for PPS-exempt hospitals).

Method of Payment

The hospital's overall PPS payment amount per discharge (before it is multiplied by the DRG weight) would be determined by adding:

(1) an updated national average standardized capital-related payment amount per discharge; to

(2) the PPS payment amount for operating costs.

During a transition period, the national average capital-related payment amount would be split into payments for:

(a) plant (i.e., buildings) and fixed equipment costs; and

(b) moveable equipment costs.

The payment amount for plant and fixed equipment costs during the transition would change from an amount based primarily on a hospital's incurred cost to an amount based primarily on the national average cost. Thus, the hospital's payment amount for plant and fixed equipment costs in any DRG during this period would combine portions of two amounts:

(i) a hospital-specific amount equal to the hospital's capital costs per discharge for plant and fixed equipment incurred during the fiscal year, as allowed under current Medicare reimbursement principles; and

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17/ This description is based on recommendations approved by ProPAC on March 5, 1986. They will be included in ProPAC's annual report advising the Secretary of HHS regarding recommended changes to PPS. The report is due by April 1, 1986.

(ii) a national amount per discharge, multiplied by the DRG weight. The national amount would be equal to the updated national average standardized capital-related cost per discharge for plant and fixed equipment, incurred by all PPS hospitals in a base year.

At the conclusion of the transition period, the capital-related payment amount for plant and fixed equipment cost would be based entirely on the national amount.

The payment amount for moveable equipment costs would be determined by the national average standardized capital-related cost per discharge for moveable equipment incurred by all PPS hospitals in a base year, updated to the year of payment. In defining the national average base amounts for movable equipment and plant and fixed equipment, costs attributed to moveable equipment could not represent more than 40 percent of total capital-related costs in the base year. Any moveable equipment cost in excess of 40 percent would be included with fixed equipment costs.

Payment Level

- Base period.--Hospital data from 1985 cost reports would be used as a base for calculating the national plant and fixed equipment capital-related base amount. Hospital data from 1983 cost reports would be used as a base for calculating the moveable equipment capital-related base amount.

- Update factor.--Payments for plant and fixed equipment costs would be updated from 1985 to fiscal year 1987 by an index of construction costs and interest rates. Payments for moveable equipment costs would be updated from 1983 to fiscal year 1987 by an index of equipment costs and interest rates.

- Return on equity treatment.--The national capital-related base payment amounts for moveable equipment and for plant and fixed equipment would include payments for return on equity in the base year. Return on equity payments would be excluded from the hospital-specific amount for plant and fixed equipment.

Transition

The blending proportions applied to the hospital-specific and national amounts for plant and fixed equipment during the transition period were not specified in detail. The Commission recommended a straight line transition schedule over a 7 to 10 year period. In the year following the transition and therafter, the capital-related payment amount for plant and fixed equipment costs would be based entirely on the national payment amounts.

There would be no transition for payments for moveable equipment costs.

Adjustments and Exceptions

- Urban/rural distinction.--These recommendations do not provide for separate urban and rural capital-related Federal base amounts. However, urban and rural hospitals would receive different amounts of capital-related payments due to other adjustments.

- Geographical cost adjustment.--ProPAC would study whether adjustments for geographic variations in capital-related costs are appropriate.

- DRG adjustment.--These recommendations do not establish a separate capital-related DRG weighting factor to account for variations in capital costs among DRG categories. Thus, capital-related costs are assumed to represent the same proportion of operating costs in each DRG category.

- Indirect teaching adjustment.--Under these recommendations the adjustment for indirect costs of medical education would not be applied to the capital-related portion of DRG payments.

- Exceptions.--This proposal does not provide for exceptions for special circumstances.

Additional Recommendations

- Reexamination of other PPS adjustments.--The Secretary would be urged to reexamine PPS adjustments, such as the adjustment for indirect medical education costs, in effect at the time capital-related costs are included under PPS.

Senator DURENBERGER. The hearing will come to order.

Today's hearing is devoted to Medicare capital payment reform. Capital expenditures were exempted from the part A prospective payment system when PPS was created 3 years ago. But the Congress made clear its intention to include capital in the system, and set itself a deadline of October 1, 1986.

In the meantime, the Secretary of Health and Human Services was instructed to prepare legislative recommendations to fold capital payments into PPS.

Last November, this subcommittee heard testimony from the Acting Assistant Secretary for Planning and Evaluation for HHS reviewing the progress on the HHS study of this issue. Since that time, the administration has made public its proposal for incorporating capital payment into the prospective payment system through regulation. This proposal calls for a 4-year transition period. According to the President and budget figures, it would reduce capital payments to American hospitals in fiscal year 1987 by $456 million and through fiscal year 1991 by $11.5 billion.

The Medicare financing reforms begun by the Social Security Act Amendments of 1983 were designed to save money, to save money for those who benefit from and those who finance the Medicare trust fund. They were not designed to actively undermine the efficient as well as inefficient hospitals. It was not the intent of the 97th Congress in 1983 nor the intent, I believe, of the 99th Congress today to use reform of Medicare payment system for deficit reduction.

Recently, I introduced with my good friend and colleague from Indiana, Dan Quayle, S. 2121, a proposal to incorporate capital expenditures into the prospective payment system. The title of that bill is the "Fair Deal Capital Payment Act of 1986," and the name has drawn a few snickers since its introduction.

There was a particular reason for choosing that name, and it had nothing to do with Harry Truman. Some of you have heard me talk about prospective payment as a contract between the Federal Government and the health care industry. It is a deal we struck to improve the way that health care is financed and delivered in our Nation. But if PPS is a deal, it has to be a fair deal. And both sides have to stick to the original terms of this social contact.

Health care providers cut costs and improve both efficiency and quality of service. Washington gives providers realistic and rational payments for the services rendered. In fact, some in Washington would have us renege on that deal using Medicare as a whipping boy for a bloated Federal budget fed by irresponsible spending policies in other areas.

This should not and will not continue. Any savings from part A reform—and they are substantial—must benefit the Medicare trust fund for future beneficiaries; not continue wasteful spending for this generation.

The hearing this morning will provide an opportunity for Senator Quayle and myself to perfect S. 2121. It is our intent to take this proposal, refine it and see a capital payment policy in law by October 1 of 1986 made by the Nation's policymakers; not by its regulators.

Despite the personal popularity of our President and the unpopularity of his incredible national deficit, this is still a nation of laws rather than of men.

The chairs and the ranking members of the authorizing health subcommittees carried that message to the Secretary of HHS yesterday. This hearing should provide a similar message today.

So now let us see what we can all learn from those who are expert in the details and the cost of hospital capital investment.

Let me begin with my colleague from Indiana, a leader in the health care issues in this Senate and this Congress from labor and human resources, Dan Quayle. Thank you for being here, Dan.

STATEMENT OF HON. DAN QUAYLE, U.S. SENATE, STATE OF INDIANA

Senator **Quayle**. Well, thank you very much, Mr. Chairman.

Let me just ask to have my statement included in the record, and then I will just make some summary comments.

Senator **Durenberger**. It will be made part of the record.

Senator **Quayle**. Mr. Chairman, I certainly agree with you that we need to reform the capital payment system. I believe that we ought to do this as effectively and fairly as we can, as you have pointed out. I do not believe that this capital payment legislation that I hope will be passed is going to be used to relieve the short-term problems in the Medicare Program. Obviously, there are going to be some short-term savings there. But where the savings are going to come is in the long term. And in the long term, there really will be some meaningful savings. And so I congratulate you and am delighted to work with you on this legislation.

I might point out for the record that we have already modified our proposal at least one time; perhaps we will have to modify it again as you move through these hearings today and look at how we are going to proceed on the legislative track.

But I did want to stop by and to enthusiastically urge this Committee to pass this legislation. I believe as we look at this legislation we ought to consider our options. I suppose one of our options would be not to pass anything. If, in fact, that happens, then we are going to have to deal with the administration's regulations on capital that are going to take effect.

Those are basically OMB regulations. Let us call it for what it is. They see a lot of savings. To refer to it for conciseness sake, these are OMB regulations. And they are interested in savings. That is it. While I understand their constraints, I feel we have a responsibility to look at this in a broader context than just budget calculations and look at its impact on hospitals. We have got to look at this in the broad context of what can be done in the long term.

Also, we must consider what will happen if we do not take any action. What may happen in the worst case, if we do not do anything, is that the administration's regulations will go into effect and we do not do anything dealing with the mandatory section 1122 requirement we put in the prospective payment back in 1983; 1122 kicks in and you have got mandatory certificate of need. That is the worst case scenario, but it is a scenario. And it is something that could possibly happen.

So, therefore, I think it is absolutely imperative that we move forward in the implementation of the prospective payment system.

I congratulate the chairman in his leadership that he has demonstrated in this area. I think that this legislation is a good step forward. And I also think that the transition period is reasonable. We have worked on this and have adjusted the blend of the hospital-specific rate the national rate so that the new system really does not kick in too much until the third or fourth year. A 7-year transition, I think, is a good, happy medium point. And I know that the chairman and many of us have been working and trying to strike that balance. And I think it is a good balance, and one that I hope that would be acceptable as we move forward.

In conclusion, Mr. Chairman, I think it is imperative that we do work together. I thank you for the cooperation that you have given to me and to the Labor and Human Resources Committee. I think it is also imperative that we get together with the interest groups out there and the administration. We cannot just let those participants stand on the sidelines and not to be a part of this.

But I really feel that it is our responsibility to pass legislation. I think we have made a commitment in past legislation to move forward. I think you are taking the right approach. And I might also point out that as we come to a final conclusion on what we are going to do on this legislation, how it is going to affect hospitals, rural, urban, all of them on these rates, that you also have a little bit greater responsibility than I as you look at this whole tax reform bill, and to coordinate any new tax measures that may have an impact on the capital investment of these hospitals. That is a different issue and something we could discuss at a different time.

But as we move in this area and begin to implement a DRG-type system for capital cost as we have for the operational side, the tax bill and particularly the tax-exempt bonds for financing and those types of things are going to have to be examined as well.

So, Mr. Chairman, I am delighted to be here today to put in my 5 cents worth and congratulate you for moving this forward. And I look forward to working with you in this area.

Senator **Durenberger**. Dan, thank you very much.

[The prepared written statement of Senator Quayle follows:]

STATEMENT OF U.S. SENATOR DAN QUAYLE (R-IN)
BEFORE THE SENATE FINANCE HEATH SUBCOMMITTEE
ON MEDICARE CAPITAL PAYMENT REFORM

March 14, 1986

Mr. Chairman, members of the Subcommittee, it is a pleasure to be here today to discuss Medicare payments for capital costs. I appreciate this opportunity.

In 1983, when Congress enacted the Prospective Payment System (PPS) for hospital inpatient services it decided against incorporating capital related expenses into the PPS immediately but instead set October 1, 1986, as the deadline for making a determination as to how to treat these expenses. That date was selected to allow sufficient time for the development of an alternative proposal to deal with capital costs.

When it became apparent last session that little progress had been made by either the health care industry or the Department of Health and Human Services in developing a viable solution, Senator Durenberger and I co-sponsored a bill designed to reform capital payments. At the time we introduced our first bill, S. 1559, we noted that its purpose was to get the ball rolling on capital payment reform and to put this subject on the agendas of all parties involved--the hospitals, the Administration and the Congress. In that regard, I believe our original bill served its purpose.

The new proposal, S. 2121, that Senator Durenberger and I introduced on Februrary 27, represents a substantial revision of our orginal bill that was achieved after much work and consultation with the affected parties. I feel strongly that this new measure is fair and equitable, particularly in light of the Administration's proposal.

I would urge the members of this Subcommittee to reject the Administration's premise that capital payment reform is a subject that should be appropriately addressed through regulation instead of legislative action. When Congress passed the statute to implement the prospective payment system, it made it quite clear that the decision concerning the integration of capital costs into the PPS was to be made by legislative action and not regulatory fiat.

Furthermore, I would urge the Subcommittee to reject the Administration's decision to use capital payment reform as simply a budget cutting exercise. The ultimate goal of capital payment reform should be to change the incentives for capital investment so that they will be based on rational economic principles employed in almost all other industries. I believe that such an approach will ultimately save considerable dollars for the Medicare Program. Fiscal constraint should not mean the imposition of arbitrary ieasures which could well have drastic effects on our health are delivery system.

Briefly, S.2121 modifies the current reimbursement ystem for capital payment by adding on a percentage for apital costs over a seven-year transition period with the ajority of the transition taking place in the later years. uring the transition period, Medicare hospital eimbursements for capital will consist of blended roportions of a hospital specific capital payment rate and national capital payment rate. The hospital specific ortion will be the allowable capital costs actually ncurred by a given hospital; thus, the hospital specific ortion will continue to be passed through on its current ost basis over the transition period. This transition eriod should be sufficient to avoid serious financial isruption to those hospitals that are highly leveraged in apital investments when the proposal is implemented. At he same time, the transition is not so lengthy that it will npede the efficiency of the prospective payment system for perating costs.

Our bill will encourage all hospitals to behave more fficiently with regard to their capital expenditures. For ie first time, strong incentives will be in place for spital managers to minimize the overall costs of new investments by selecting the right financial mix and by making capital investment decisions that are sensitive to marketplace conditions.

In recent discussions of capital payment reform, I have heard interested parties express their concern that the integration of capital into the prospective payment system could adversely affect our efforts to deal with the problem of indigent care and also have a detrimental impact on new technology and on rural hospitals. While all of these concerns are certainly legitimate, they really have no bearing on capital reform. Whatever form that capital payments may take, they are not going to solve our society's health care needs of the poor. As for capital reform's effect on new technology, any adverse impact really relates to the adequacy of the rate for the individual DRG in question. Similarly, where rural hospitals are concerned, the real problem relates to the adequacy of the payment between the urban and rural classification--and Congress has taken some steps to address these kinds of inequities through the establishment of rural referral centers.

We in the Congress must remember that if we are unable to meet ~~our~~ own self-imposed deadline of October 1, 1986, for passing a capital bill, then Section 1122 of the Social

Security Act will become mandatory for all States. Neither Section 1122 nor its counterpart under our health planning law, the Certificate of Need Program, has been successful in containing health care costs. If anything, both of these programs have acted as a disincentive to the development of a competitive health care marketplace. To put States in the position of having to participate in such a regulatory program would only be to repeat our previous mistakes by giving new life to failed policies of the past.

At the same time that I recommend our bill for your consideration, I urge this Subcommittee to coordinate its actions on Medicare capital payments with its actions on the provisions of the tax reform bill that will affect hospital capital investments, such as tax exempt bonds and the refunding of debt capital. Clearly, it would be quite unfair not to look at the ramifications of such cummulative actions.

I urge the Subcommittee to take action on capital payment reform. The time has come for us to move forward on this issue and to stick to the deadline we set for integrating capital costs for Part A reimbursement into Medicare's new prospective payment methodology. Hospital capital costs represent only approximately 7 percent of Medicare's hospital payments. However, capital payments significantly affect Medicare's expenditures for operating costs. It is now time for us to address this issue and to align the incentives for capital reimbursement with the prospective payment system.

Thank you again for the opportunity to testify. I appreciate your time and attention, and I look forward to working with you on this issue.

Senator **Durenberger**. I think one of the concerns that both of us have in approaching this issue is that both the definition of "capital" and the definition of "hospital" is sort of up in the air these days. And you referred to the other obligations that I have sitting up here. For example, for tax-exempt bond treatment in the Tax Code. And probably nowhere more obvious as we approach that issue—how complex this issue is becoming in this particular business.

It may not be true in highway building, and it may not be true in solid waste disposal or prisons or something like that, but, clearly, this is an industry in transition. And the difficulty that we face as policymakers in wanting to make some money while we are doing this process is that the people that are really going to make money for us are the providers. We are not going to save money ourselves by hacking away at the spending side. They are the ones that can save money for us by changing the way they use facilities. And we can help them change the way they use facilities by the way we deal with the financing of those facilities.

So I appreciate very much your contribution to this effort and in the area of health planning and the other areas that are sort of relative to this issue.

I think one of the things we can count on is that this body and our counterparts on the House side are going to act this year on a piece of legislation. That is the message we tried to leave with Secretary Bowen yesterday. That he may have a June 2 deadline of some kind to go to regulation, but we also have an October 1 deadline to go to legislation; we intend to make that.

So thank you very much.

Senator **Quayle**. Thank you, Mr. Chairman.

Senator **Durenberger**. Our next witness is Bob Helms. All right, Mr. Robert Helms, Ph.D., Acting Assistant Secretary for Planning and Evaluation, Department of Health and Human Services.

STATEMENT OF DR. ROBERT HELMS, ACTING ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Dr. **Helms**. Mr. Chairman, let me say I am, again, happy to be here. It is my pleasure to start off by presenting you with a copy of the report to Congress, "Hospital Capital Expenses: A Medicare Payment Strategy for the Future," which the Secretary has this morning presented to the Congress.

[The document is in the official committee files.]

Senator **Durenberger**. This is a version of Carolyn Davis' teeshirt. [Laughter.]

Do not tell them what I did, Randy. [Laughter.]

We know at least half your heart is in there, Bob. We would not toss it.

Dr. **Helms**. I will not read my statement, but ask that it be submitted for the record.

Let me also just take this opportunity to thank the numerous people that have worked on this report for 2 years. It has been a frustrating project for a lot of us. I would especially like to thank Randy Teech, Kathy Means, and Bonnie Lefkowitz who at one time or another headed this project in my office. There were numerous other people that also worked very hard on it.

Let me say also that my Xerox budget has been cut, and this has been presented to NTIS and also the Commerce Clearing House. It should be available very soon.

I would ask all the people around town—they never complain about Xeroxing leaked documents—so I would ask them please to pass this one around, too.

The comments which I submitted for the record are taken from the recommendation chapter of the report, so without further ado, I would just say that I am prepared to go through our proposal using the charts, if you would like to do that.

Senator DURENBERGER. I think, Bob, that would be a good idea. And if you would sort of—maybe you can even put the thing up there. The reason we are going to go through it is so everybody in the place can see this.

Dr. HELMS. Let me say copies of the charts we will be using are included in the packet of the testimony.

Senator DURENBERGER. Everybody in the place have a copy of his testimony? No. If not, let us put the charts up there so we can all watch them.

While you are doing that, let me endorse for everybody who is here and those that may read about this hearing—and I will just repeat what I said last November, I think, and that is my personal compliments to not only to Bob Helms but to Randy and Kathy Means who is no longer part of the team, and to Bonnie Lefkowitz; that I think that the people who were personally involved over the last 2½ years in this study have produced an awful lot of very valuable information for all of us with a relatively small budget, but a high level of personal competence and commitment to this process. And the fact that the politics of the moment do not permit what in my opinion might necessarily be the personal opinions of the investigators here being reflected in the recommendations of the administration is in no way a reflection on their individual talents or commitments to the analysis of this very serious issue.

So, Bob, with that.

Dr. HELMS. All right. I am ready to start.

Thank you very much for your remarks. Let me say that since I was here last time, this policy is part of the President's budget. It does have savings in it, but I would point out that I think our proposal—there is a lot of good information in the report for looking at options; information that, I think, will be helpful to anyone here on the Hill and in the industry. I do ask people to read it carefully.

I would characterize our approaches, your bill and ours, as having a lot in common. Ours saves more than yours, obviously. But it does have a lot of features in common.

And I will say again we will be very willing to try to work with you and the Congress in whatever you do between now and June 2 and also between now and October 1 to provide you with what information and analysis that we can.

Now the approach that we adopted is to incorporate capital payment amounts into the nonlabor portion of the PPS standardized amounts.

I am going to work off this chart. We were supposed to have two stands, but we don't, and I would just ask you to put that down below there. And, hopefully, you can see that.

But I think the advantages are that it links the payment—as does your proposal—to Medicare patient volume, and not to the asset value of each hospital as under cost-based reimbursement.

It also encourages prudent investment. In other words, it gets away from the criticism of the old cost-based system which was that people had an incentive to maximize capital revenue.

It also has the advantage of creating a set of incentives so that we think hospital management will look at capital investment not in terms of how to game the reimbursement rules but in terms of what is economically efficient for that particular hospital in its market, given its local prices for capital and other inputs.

And, also, we would argue it eliminates the needs for health planning. And we applaud your efforts to repeal 1122.

As a kind of review, this chart is a very simplistic view of how we calculate the DRG payments for each hospital now under the system for operating costs. It divides the average payment of a discharge into a labor and nonlabor portion—in order to adjust the labor portion by the wage index.

What we would do in our proposal is incorporate the capital and noncapital components into the nonlabor portion so that you would come out with a standardized urban and rural rate. That then gets multiplied by the DRG weights to distribute payments more for those DRG's which are more resource intensive and less to those which are less resource intensive.

So in that sense, when we include capital in here—nonlabor portion—those hospitals that are treating more of the more intense DRG's will get more capital payment over time, as you phase this in. That is the basic approach that we are proposing.

Now the computation of the national rates—we are saying that we would go back to 1983 audited cost reports to compute the national rate. We will take out return on equity and interest offset, and we will then update this amount. There are two ways we could do this. We could do it by the percent increase in capital expenditures, which are increasing at about 17 percent, I think, since that time on an annual basis. Or you can use a price index for capital.

HCFA has a component for capital in its market basket calculation. We think it still needs some more work. But you can update that 1983 amount to 1986 with it or a similar inflator for the operating and capital payments. After that, the update factor would be the same. It would be incorporated into the Secretary's decision of the annual update factor for the whole PPS system. And that would occur throughout the transition to the national rate and every year thereafter.

Now let me talk about the transition. We are proposing—very similar to the one in your proposal, but shorter—a 4-year transition period for interest and depreciation. This would decline on the hospital specific amount by 80, 60, 40, 20 and by the fifth year, 1991, it would be all in the national rate.

We have a separate 3-year phaseout of return on equity and interest offsets. And that goes down from 75 percent of that amount in 1987, 50 percent, 25 percent. And then by 1990, it would be zero percent. That is different simply because we took the reconciliation language of 3 years and adopted that rather than not have any phaseout of those two items.

Senator **Durenberger**. And the major difference, Bob, with our proposal in this is in the relationship between the national rates portion and the—you want to explain it to everybody?

Dr. **Helms**. You have two major differences here. One, you have extended the transition to 7 years, a true 7 years. And, also, you have what we call an uneven blend. In other words, instead of reducing yours on a straight line basis, you have kept the hospital specific payments relatively high in the early years starting off at 95 percent, 90 percent and so on.

The other thing you have done—and all of these make it easier on those hospitals who have high capital obligations—is to use actual cost reports for each year.

What we are proposing instead is to freeze the hospital specific amount to 1986 levels and then update it by a capital index.

Senator **Durenberger**. What is the difference between the two? What is the impact of one versus the other? The rolling base versus the index adjusted 1986 base?

Dr. **Helms**. Well, actually, I am getting ahead of myself, but we would actually have a "lower-of" provision.

Senator **Durenberger**. All right.

Dr. **Helms**. But to answer your question, the essential difference is that ours would freeze it on the rationale that there has been a lot of capital investment out there that is probably inappropriate, and we would like to freeze it. It saves us some money.

Under the rules now, a hospital is allowed to put onto the cost reports, when it comes on line with a new investment or new equipment, the interest and depreciation for that year. If that happens after the start of the transition in your system, they would get the blended amount. In other words, in the first year, 95 percent of that amount.

In our proposal if that happens, they would not be allowed that.

Let us go ahead to the next chart.

Senator **Durenberger**. This where we get to define inappropriate?

Dr. **Helms**. Right.

Senator **Durenberger**. Is that the word you used?

Dr. **Helms**. What we have here is just some evidence on what has been happening in the bond market, and to just show you that there has been excluding refinancing, a big increase in bonds, hospital bonds, issued in 1985. As you well know, this had to do with some expectations about the treatment of tax-free bonds, but it creates a problem for us in the sense that this is all tied to future plans for additions to capital. We see that as a potential addition to the allowable capital costs in future years, and a big cost to us.

Senator **Durenberger**. What would the refinancing chart look like? Or how much would it add? What is that in dollars for 1985? Twenty-one?

Dr. **Helms**. That is $21 billion.

Senator **Durenberger**. How much refinancing was done last year? Do you recall?

Dr. **Helms**. We do not know that now.

Senator **Durenberger**. Do you have a ballpark figure?

Dr. **Helms**. We were told that this excludes refinancing and we are trying to get that information. We do not have it yet.

Maybe some of the other people testifying later this morning can answer that.

Senator **Durenberger**. Hopefully, they will.

Dr. **Helms**. Let us go ahead to the next chart.

This is a review of how hospitals will be paid under our proposed system. The current payment really refers to the operating cost payments where we have the current labor and nonlabor standardized amounts computed differently for urban and rural hospitals, times the DRG weight. For the teaching hospitals, that amount gets multiplied by the indirect medical education adjustment.

The capital payment comes in two parts also. The first one is the national rate which takes the blending percent, such as 80 percent in the first year, times the capital national amount—which would be the standardized amount. This account gets multiplied by the DRG weight, as I said earlier, so that the capital amount, which is the national rate, reflects the intensity of use of resources in each DRG.

On the hospital-specific side, we would pay the blended percent such as 80 percent in the first year of a hospital's specific depreciation and interest, what is on their cost reports in 1986, updated by that index factor to 1987.

We would then take a different blending percent such as 75 percent in the first year for the return on equity and interest offsets. However, to avoid paying an inflated amount to those hospitals whose cost reports would have declined anyway, we have a "lesser-of" provision in there to pay the blended percent times what is on the actual audited cost reports for that year.

Of course, there is a lag. When you get the information, HCFA has normal procedures for starting out on the basis of estimates and then making corrections after the audits are done.

The rationale for this is that the percent change in capital expenditures is at the top of the chart. You can see the actual expenditures in red at the bottom of the chart. But the percent changes have really stayed up around 17 percent per year in terms of the total capital expenditures that have been paid out by Medicare at the same time that the occupancy rates in hospitals have been going down. We have created a situation here where hospitals have still been pumping out a lot of money into capital. HCFA is obligated to pay for that under cost reimbursement, at a time when occupancy rates are going down.

I do not think we have a chart, but included in the packet is data on occupancy rates in MSA's. This chart is in your packet. When we adjust occupancy for length of stay, we have about 11 percent of the MSA's with occupancy rates that are under 60 percent, and approximately 55 percent of the MSA's have occupancy rates which are 60 to 70 percent. So we do have a good deal of excess capacity out there in hospitals.

Of course, I will point out—I am sure the point will be made that has been made to us by the hospital industry—that a lot of this so-called excess capacity is a result of people being unwilling to give up on licensed beds because of the trouble they have had with the planning process.

This is a rather complicated chart, but let me try to explain it this way: Several years ago there were numerous experts who were making estimates about what future capital requirements were going to be in the hospital industry. We commissioned a study to take a look at all of these independent studies. And one of the things that they found was capital expenditures, in the decade from 1986 to 1990, were very sensitive to their assumptions, particularly about inflation and utilization. They were also sensitive to the assumptions about HMO enrollment and the renovation cycle.

Under the assumption of 5-percent inflation, a 30-year cycle, HMO enrollment up near 32 million by the end of this decade, and constrained utilization, the projection said that we would need approximately $70 billion in the hospital industry for capital requirements in that decade.

We estimate that our proposal will still pay out about $46 billion over this period of time. In other words, what we are trying to say is that is going to be approximately 65 percent of the capital requirements over this decade.

Medicare's historic share is centered around 40 percent, which would calculate to something like $28 billion. So how good are the assumptions behind this estimate of future capital requirements? I would ask you to look at some other charts here which are included in the packet.

Here we have projections for total admissions for hospitals which look rather steady here, and also admissions for those over age 65. There is a little increase to reflect the aging of the population here.

May I have the next one?

At the same time, we see actual data that total patient days in hospitals have declined. And, of course, this is a direct result of the drop in the length of stay.

As an economist I have to be cautious about predicting future inflation rates. You know, economists do not have a very good record at this. But the official projection in the trustee's report and from the Government accounts and so on are for modest increases in the inflation rate, but very close to the 5-percent level assumed in that $70 billion figure. So you can make your own guesses about inflation.

But my point is that even if you take these assumptions and say that $70 billion is maybe an underestimate, we might have more inflation and so on, we think that under this proposal we are still going to be paying out a relatively high amount compared to Medicare's historical proportion for paying for capital.

HMO enrollment is also important. That projection was talking about 32 million enrollment by 1996, but projections are now that we will reach 30 million by 1988. We are around 20 million now. And the projections are that this will increase. As you know, this administration, as well as you, has been out there pushing HMO's. And all the hospital magazines that I read lead me to believe there is a great deal of actively, not in just federally qualified HMO's, but all kinds of other at-risk plans. They attempt to save money by keeping people out of hospitals and treating them by more efficient forms of care.

That concludes the presentation. I tried to go over this rapidly. I think it explains our approach. And as I said before, we will do our best to supply information and analysis to you as you in Congress proceed on this in the next few months.

Senator DURENBERGER. Let me ask you to respond to the recommendations of the Prospective Payment Assessment Commission which I think came out in the last few days relative to capital, one of which—I mean if you are not familiar with all of them—I mean one of the concepts, obviously, you are familiar with is the possibility of treating the two kinds of capital investment differently. One for fixed capital, the building and the real estate, and the other being the so-called moveable equipment that goes into the delivery of health care.

Suppose we were interested in sort of a two-part approach to this system as PRO PAC has recommended that we should be. What would your reaction be to that?

Dr. HELMS. Well, first of all, I have not had a chance to look in any detail at PRO PAC's recommendations. We certainly looked at that issue a great deal. And it is one of several things. I would ask people to go back and think about what is the purpose of doing this.

Senator DURENBERGER. Purpose of doing what?

Dr. HELMS. Of separating out fixed and moveable capital.

Senator DURENBERGER. Because they are two different kinds of investments, I take it, for very different purposes.

Dr. HELMS. Right.

And I think the notion that somehow with moveable equipment you can go ahead and put that into the national rates and then the fixed equipment is longer lived and there are more bond obligations for that, and, therefore, you ought to space that out over time.

However, we looked at all of these proposals on the fixed and moveable equipment and really thought a better way to get at this, if this is what you really want to do, is to do the things that I think you have put into your proposal—extend the transition, make it an uneven blend. All of those things help the high capital cost hospitals.

We have problems with trying to break out fixed and moveable or old and new assets. We tried to avoid all of those things because we think we put HCFA, who has to administer this thing, in the very difficult position of making these distinctions. It is, I think, an unnecessary complication.

Senator DURENBERGER. But the problem is you and I really need to put ourselves in the position of the chairman or the board of trustees or something like that of a health center or hospital or whatever we are going to call them. And each of them is somewhat differently situated. Some people probably can make equipment purchases. We will assume that everybody each year has to make a certain amount of equipment purchases.

Some people are doing well enough so they can make them out of current earnings or some kind of a set aside from current earnings so they do not have to go to the debt market. But even that has a cost associated with it.

Dr. HELMS. Right.

Senator DURENBERGER. Some other people have a paid off facility, not a lot of debt against their equity, and they have got a lot of borrowing capacity. Now then there is a second kind of person who just built. They have got the $500 million or $100 million hospital, building, land, sitting out there. And over time, what is inside that $500 million investment with its big debt service hanging over it has to be remodeled and new technology and whatever.

But they are differently situated in terms of their capital. A third or fourth or whatever it is I am on now kind of an institution would be one that I think of as akin to the farmer who owns a $3,000 per acre farm and all of a sudden it is only a $500 per acre farm. I mean there are devalued hospitals in this country, and not all of them are going up in value or even staying even in value. Some of them because of location, because of the competition factor, whatnot else, may be going down in the overall value or equity in the facility. And yet they need to deliver certain competitive quality medicine. And to do that, they need to make an annual set of investment.

But it strikes me that one of the reasons you pull apart or even consider pulling apart the moveable, so-called, equipment investment in this kind of an approach from the capital is because different hospitals are differently situated in terms of their access to being able to finance this.

How would you react to that?

Dr. HELMS. Well, if you are saying that you would go ahead and include moveable equipment in some kind of plan and keep the fixed equipment as a passthrough, I mean one of our objectives was to get out——

Senator DURENBERGER. Not necessarily. Forget the passthrough issue, the old capital, new capital kinds of issues. Just thinking about ongoing. Would you set up a different factor in your prospective payment system for moveable from the factor that you would set up for fixed?

Dr. HELMS. Well, if I understand—and I am not sure I do—but if I understand your question, I think that if we did that it would be very complicated. I could never really understand—if you are just concerned about the hospital's revenue, the approach we have taken with this thing is to maintain a sufficient amount of revenue compared to what they got under the old system. Have a transition which keeps revenue relatively high early on and gradually goes to the national rate. As long as hospitals are getting sufficient revenue that's all that matters. Developing a different payment system, for the different classes of capital, I find unduly complicated because you then put HCFA in the situation of having to distinguish between the two types of capital.

That is a difficult auditing problem. Some people say, well, it is no problem, but, believe me, when you get to dealing with these kinds of accounting issues, there are always people who are going to try to figure out ways, as we think they are doing now with operating and capital, of moving one to the other, whichever is to their advantage.

Our whole approach is to get it into one payment where the hospital gets the money they need and then they decide how they want to use the imputs; not to keep a separate payments system for the two classes of capital.

Senator DURENBERGER. And I have not read it, but I have been given to understand secondhand what they are recommending is, in effect, they are probably dealing with the transition. Nobody argues that at some point in time, 4, 7, 10 years out there, there will be a percentage factor added onto each DRG to reflect capital in the larger sense.

But I think what they said that dealing with the equity as between institutions the variability in capital cost is, among institutions, largely on the fixed investments. That most hospitals, DRG by DRG, will have a much more comparable over the next 4, 7, 10 years, plus their historic carryover, comparable kind of capital investment needs as far as moveable equipment is concerned. Where the variations will come will be in what they walked into 1986 with in terms of debt service on their facilities.

Dr. HELMS. It is agreed that hospitals have different situations. They are in different points in their investment cycles and so on, and that was certainly the whole theory behind a transition system of keeping the hospital-specific part high in the first years. Whatever their situation is, they continue to get what they have been putting on the cost reports or a percent of it.

Senator DURENBERGER. How much does the Department estimate will be the national average standardized capital payment amount in fiscal year 1987 under its proposal and under S. 2121?

Dr. HELMS. As you know, HCFA is developing the regs and would have to compute this on the basis of the annual update and the related data. But we think that our standardized amounts and yours would be the same and about $300 on the urban rate and about $180 on the rural rate.

But that is not how much they are going to get per discharge. Remember, on both of our plans, they are going to be getting, in the first year, a very large portion of what they were getting per discharge on the hospital-specific side.

Senator DURENBERGER. On what basis does the Department of Health and Human Services conclude that it has the legal authority to implement its capital reimbursement policy by regulation? Has there been a written legal opinion from legal counsel to this effect?

Dr. HELMS. Yes, there has. Both ours, and I think also the Congressional Research Service has come out with a similar interpretation.

The legal interpretation that we have is that we have to proceed by regulations until such time as the Congress passes a different plan. And, therefore, the Secretary is obligated to go ahead with this, and those regs are in preparation.

Randy has reminded me that the interpretation is that unless we have a reg in place, we cannot pay for capital after the 1st of October.

Senator DURENBERGER. Thank you.

Max, do you have a statement or questions?

Senator BAUCUS. Thank you, Mr. Chairman.

Dr. Helms, Senator Durenberger, probably because of the bills introduced and because of his position as chairman of the subcommittee, has asked a lot of general questions. I generally agree with the questions that he has asked, but I am going to ask you questions that deal much more in the specific area with rural America.

The first question is: If you could help us, what is the degree to which the capital cost proposals for sole-community providers is the same or different from the way the proposal treats operating costs.

Dr. HELMS. What we are proposing for capital for the sole-community providers is to, in essence, carry out the present payment policy for all these hospitals. As you know, there are certain standards that the people have to go through to be qualified as a sole-community provider. There are roughly 380 hospitals in the country that currently qualify.

Generally, that policy is designed to identify those which are out in rural areas that are isolated for various reasons—geography or weather conditions or distance and so on. We are proposing that on the capital side they would still get the same percent as on the operating side. They would get 75 percent of their cost on the hospital-specific basis—the same as on their the operating side—and 25 percent on the national rate. We actually think that because of this they will be a little bit better off getting some percent on the national rate than they would be if it were 100 percent from their hospital cost reports.

Senator BAUCUS. But is there any significant difference between the way the proposed would treat capital versus operating costs for sole-community providers or is it just straight across the board at 75 to 25 with no differences? The only difference being is that one is capital and the other is operating.

Dr. HELMS. That is right.

Senator BAUCUS. Now does that also mean that the 75 percent cost based reimbursement would be for sole-community providers to be continued indefinitely as is the case of operating cost?

Dr. HELMS. That is right. Until it is determined at some future time that somebody could figure out a way to put them into the prospective payment system. But we are proposing that that remain permanent.

Senator BAUCUS. Now does that 75 percent cost base reimbursement apply to actual capital cost incurred today or tomorrow or whenever this is put into place?

Dr. HELMS. That is right. Under the old reasonable cost rules, which HCFA now has for capital on the cost base reimbursement, they would continue to fill out the cost reports and whatever they put down on there, they would get 75 percent. Meanwhile, they are getting a 25-percent adjustment on the national rate, depending on what DRG's they have.

Senator BAUCUS. That, then, also means that 75 percent would not be based on past capital costs, minus some adjustment.

Dr. HELMS. That is my understanding, yes. Current cost reimbursement.

Senator BAUCUS. Yes.

Would a sole-community provider, to quality, be able to opt out under your proposal, opt out of that status and switch?

Dr. HELMS. Only if they opted out of sole-community provider status.

Senator **Baucus**. That is what I mean.

Dr. **Helms**. And then they would go under the regular rules, unless you are talking about them opting out of Medicare, and I do not think that is——

Senator **Baucus**. No. I am just talking about them opting out of there.

Dr. **Helms**. No. They cannot just opt out of that, if what you mean can they just take 100 percent cost reimbursement, no, they cannot.

Senator **Baucus**. Would a hospital be able to opt out for capital cost reasons but not for operating cost reasons?

Dr. **Helms**. No.

Senator **Baucus**. Do you have any figures on the financial impact of the proposal on sole-community providers, hospitals, by size, by region or State or type of ownership? Is that broken down in any way?

Dr. **Helms**. Yes, we do.

Senator **Baucus**. How is that broken down?

Dr. **Helms**. Well, we can break it down, I think, into regions. We cannot get down to individual hospitals. As a matter of fact, we are restrained by the agreements with the AHA on the data that we cannot release that. I mean the contractor, ICF, cannot even release it to us.

But we can do it on broad areas, such as States. And we can do it on ownership classification.

Senator **Baucus**. Can you do it by size as well?

Dr. **Helms**. Yes. We have got a lot of capability, I think, to break it down.

Senator **Baucus**. Could you provide that information, please, for the record?

Dr. **Helms**. Yes, we can do that. I would be glad to.

[The information from Dr. Helms follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of the Secretary

Washington, D.C. 20201

APR 4 1986

Mr. Edmund J. Mihalski, C.P.A.
Deputy Chief of Staff for Health Policy
United States Senate
Committee on Finance
Washington, D.C. 20510

Attention: Shannon Salmon

Dear Ed ~~Mr. M~~ihalski:

Enclosed are answers to the two questions from Senator Packwood you sent to me on March 20, 1986.

Sincerely,

Bob

Robert B. Helms, Ph.D.
Acting Assistant Secretary for
Planning and Evaluation

Enclosure

Question: If a hospital has a capital debt which stretches out for 30 years, is a four year transition period with a straight-line phase out of the hospital-specific portion sufficient for such a hospital to meet its debt obligation?

Answer: In the first place, we do not think that Congress ever intended to guarantee that investments made by hospitals would be paid by Medicare. In addition, Congress specifically warned hospitals that debts incurred after 1983 were likely to be treated by Medicare in a manner different from the treatment afforded older obligations. Therefore any debt, and especially any debt incurred after the date set by Congress, was incurred with the understanding that Medicare did not guarantee its repayment. The interest rate presumably reflected any risk perceived by investors.

Even under the current pass-through system, Medicare in general does not pay all of a hospital's capital and other costs. Rather it pays the proportion of the bills that Medicare days represents of total days. Therefore, the investors and the hospital were aware at the outset that other sources of revenue would be required if the hospital were to be able to pay off its notes and to pay the interest on them. It is still true that Medicare revenues must be supplemented with revenues from other sources.

At the same time, the Prospective Payment System should provide sufficient funds to pay the interest and principal on the debt if the hospital has a sufficient number of Medicare patients. Hospitals which are not competitive enough or which do not have other non-Medicare sources of revenue may not be able to pay their bondholders.

Hospitals which are competitive are making profits on their operating costs under the Prospective Payment System. These profits added to the capital payments made under the President's proposal should allow efficient competitive hospitals to pay the interest and principal on their bonds in a timely manner.

Question: Moving to a per case payment for capital will redistribute the pool of Medicare dollars differently across hospitals than a cost reimbursement formula. How does the Administration's proposal assure that this redistribution occurs gradually?

Answer: The question really has two parts: One part concerns the distribution of Medicare patients; the other concerns the capital costs per case. Nothing in the Administration plan or any other plan will "save" a hospital which is losing Medicare patients because it cannot compete with other hospitals in its area. Even cost reimbursement will do little to save a hospital which is losing cases to other hospitals because it is not in a good competitive position unless it also loses non-Medicare patients such that the proportion of days is unchanged.

The Medicare payment per case is to be phased in over ~~five~~ four years. While a hospital may get a payment less than its capital costs, it should get a sufficient amount to cover its old capital expenditures and this is all that Congress promised in its 1983 "sense of Congress" statement. Certainly by 1991 when all hospitals are paid solely on the basis of the national rate, most of the old capital committed under cost reimbursement will be off-line. The new capital should have been committed with an eye to the probability that it would be paid for under some prospective payment scheme. Therefore wise managers should be able to make their capital debt repayments easily.

Senator **Baucus**. Are you convinced that no sole-community provider will close because of these capital cost changes?

Dr. **Helms**. Right. [Laughter.]

I am convinced that they would not close because of this policy. They may close for other reasons, but not because of this.

Senator **Baucus**. As you know, there are sole-community providers and there are sole-community providers. What I am really getting at is that all hospitals in Montana are rural providers but for four because they happen to be in the city of Great Falls and Billings, two of the larger towns in the State. The fact is Montana is a big State. There are a lot of other towns in Montana that qualify under the classification of rural providers. One of the other cities happens to be Helena, the State Capital. Because it is the State Capital, it is the State government there and so forth, and it has fairly extensive capital equipment. And I am wondering whether the proposal makes any adjustments for various kinds of rural providers, because, obviously, some of them are in much different situations than some other.

Some sole-community providers are very, very small hospitals in very small towns and 12 to 20 beds. And other sole-community providers are larger, different needs, different purposes, serve different people. And I am just curious to the degree to which your proposal makes adjustments for those kinds of hospitals like, say, St. Peters Hospital in Helena, MT.

Dr. **Helms**. If the hospital is a regional referral center, it would get the urban rate. It will get that on capital as it is getting on the operating side. But there are no other special provisions. However, I will point out that by leaving this at 75 percent on the cost side for the sole-community providers, they are getting an allowance under the reasonable cost rules for that extra capital which your expensive hospital has already.

Also, if that hospital—on the 25 percent they are getting on the national rate—if their case mix is more severe and so on, they are going to get more capital payment even on the national rate.

Senator **Baucus**. What about indexing? When capital costs are updated for future years, does your proposal provide for the same indexing per capita cost for both rural and urban hospitals? Is it the same indexing that is applying to both?

Dr. **Helms**. Yes. I think that is the same as the procedure on the operating cost.

Senator **Baucus**. What about an exceptions provision? Have you looked at that? I know you have. Why don't you tell us for the record.

Dr. **Helms**. We have looked at it. We have not come up with an exception process that we think is clean enough to make it work. So we have not recommended an exceptions process, but we are perfectly willing to look at proposals that you or anyone else can come up with and try to analyze them. We are actually, I think, going back and look at some of these ourselves.

But we, of course, can tell you we will look at this exceptions process just as we do with outlyers and operating costs in a budget neutral way. If you won't let us take it out of the Small Business Administration, then we will have to take it out of the national rates, I suppose.

Senator **Baucus**. But do you have an outlyer?

Dr. **Helms**. No. We do not have an outlyer policy included in our proposal.

Senator **Baucus**. Would it make sense if you could outline for us—I once asked you yesterday—the least difficult exceptions provision or the least difficult outlyer provision. I know it is tough. I know it is difficult. But I think we owe it to ourselves to look at that and see whether there is a way to put that together.

Dr. **Helms**. Everyone that I have looked at looks extremely complicated. And the more I look at it, you know—so picking the least difficult, I am perfectly willing to try to look at those to see if we can find something that works. But we have to go to the Health Care Financing Administration and the people who have to administer this and work out with them the details about what is workable. It is just very complicated, and I am not convinced that we could make it work.

Senator **Baucus**. I appreciate that. I know it is difficult, but I think we are going to have to look at that because I know we are going to run up to situations that are critical.

All right. I have no other questions, except that I just feel that we are going to have to extend the length of this transition period, frankly. I am sure Senator Durenberger mentioned that during his opening statement or in questions. But it just seems to me we are going to have to compromise here somewhere, and I hope that we do that very quickly rather than on some long, protracted basis.

Senator **Durenberger**. Max, thank you very much.

And, Bob, we thank you for your testimony; Randy, for your help; Kathy and Bonnie and everybody else that has been involved in this project.

Thank you. You can take your charts or you can leave them. Maybe somebody else wants to use your charts in another presentation.

[The prepared written statement of Dr. Helms follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

STATEMENT

BY

ROBERT HELMS, PH.D.

BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON FINANCE

MARCH 14, 1986

Mr. Chairman, distinguished committee members, my name is Dr. Robert Helms and I am Acting Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services.

It is a pleasure for me to appear before you this morning and to present the Department's report on capital related expenses for inpatient hospital care. My office has had policy development responsibility for this issue within the Department. The report includes useful information regarding capital finances in the health care and other industries. It includes a discussion of alternative approaches for incorporating capital into perspective payment system, and finally it contains a discussion of the Department's recommended approach.

As you know, Congress in the Social Security Amendments of 1983 decided to exclude capital related expenses from the prospective payment system until October 1986 and directed the Department to study ways that capital might be incorporated into the prospective system. The Administration's policy is an outgrowth of our study effort.

I have appended to my opening remarks: (1) an outline of the Department's proposed method of incorporating capital expenses into the prospective payment system; and (2) a rationale for the proposed method. We will be pleased to work with your staff, as we have in the past, with the development of your own proposals in this area.

I do not intend to read from the statement, but provide it to the committee as background information to the chart presentation I have prepared. The charts should facilitate my explanation of the Department's proposed policy and reasons for its formulation. With your permission Mr. Chairman, I would like to proceed with the chart presentation. Copies of the charts I will use are attached to this statement.

MEDICARE PROSPECTIVE PAYMENT FOR CAPITAL RELATED EXPENSES

APPROACH:

- INCORPORATES CAPITAL PAYMENT AMOUNTS INTO THE NON-LABOR PORTION OF THE PPS STANDARDIZED AMOUNTS

NATIONAL RATE:

- 1983 AUDITED COST REPORTS EXCLUDING ROE AND IO
- UPDATE TO 1986 BY CAPITAL COMPONENT OF MARKET BASKET
- UPDATE TO 1987 AND THEREAFTER BY PPS UPDATE FACTOR

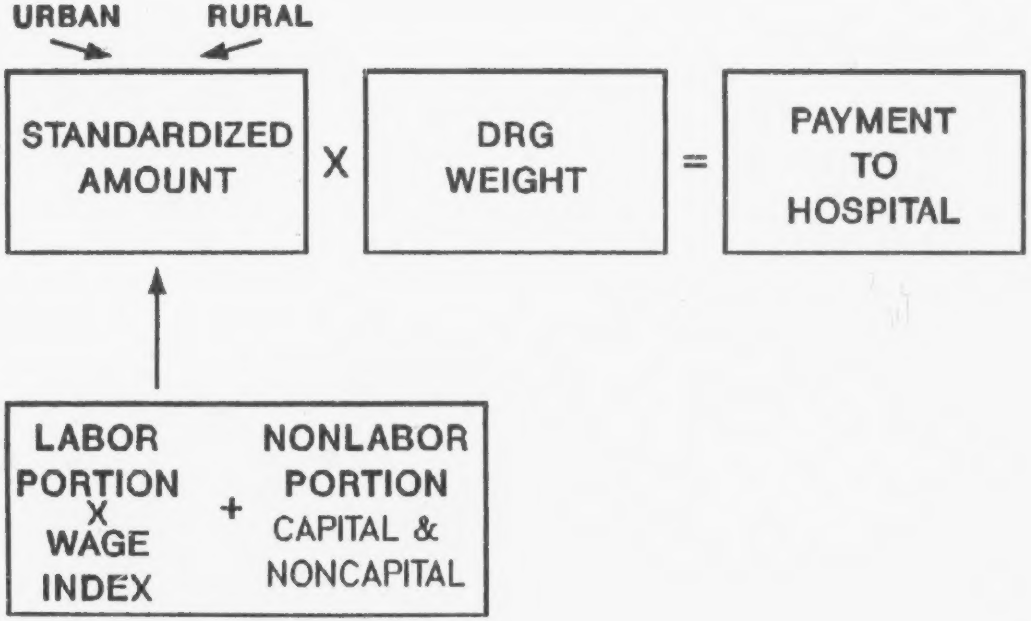
TRANSITION:

- FOUR YEAR-EVEN BLEND FOR HSP DEPRECIATION AND INTEREST
- THREE YEAR-EVEN BLEND FOR HSP ROE AND IO
- HSP FROM 1986 COST REPORTS UPDATED BY CAPITAL INDEX
- HSP PAYMENT LESSER OF COMBINED HSP AMOUNTS OR AUDITED COST REPORTS

ADVANTAGES OF INCORPORATING CAPITAL EXPENSES INTO PPS

- LINKS PAYMENT TO PATIENT VOLUME; NOT TOTAL CAPACITY OR VALUE OF ASSETS
- ENCOURAGES PRUDENT INVESTMENT; NOT MAXAMIZATION OF REVENUE
- IMPROVES EFFICIENCY; DOES NOT ENCOURAGE SUBSTITUTION OF CAPITAL FOR LABOR
- ELIMINATES NEEDS FOR HEALTH PLANNING

PAYMENT CALCULATION



URBAN

RURAL

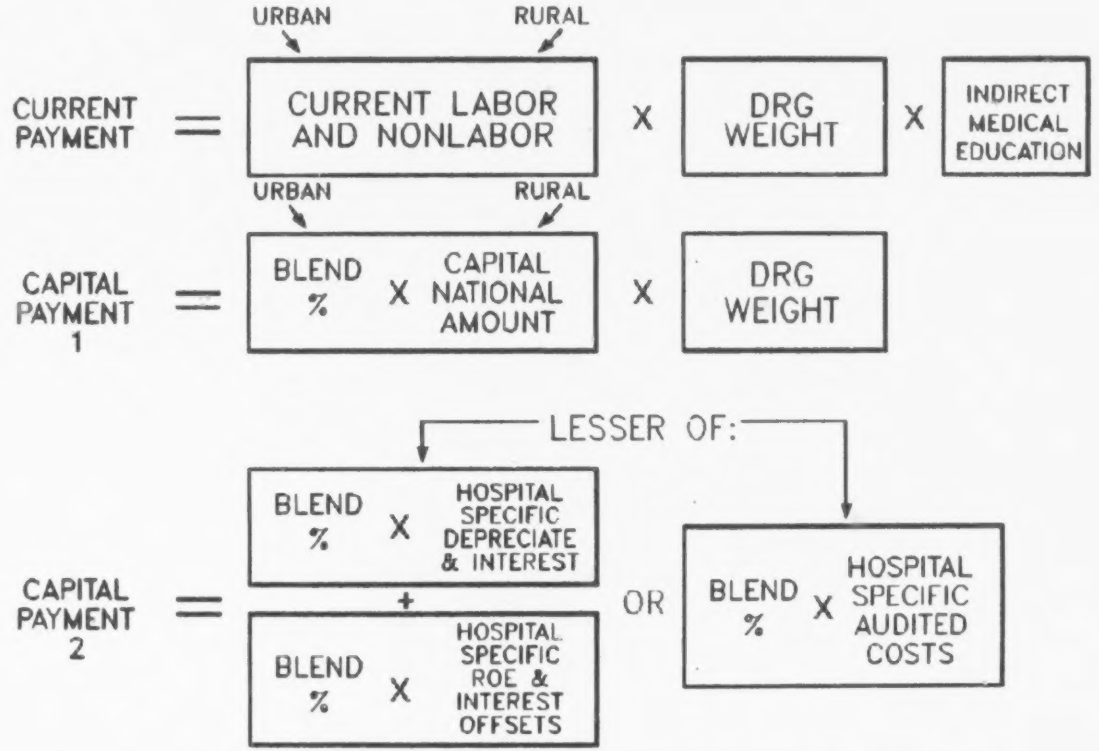
STANDARDIZED AMOUNT X DRG WEIGHT = PAYMENT TO HOSPITAL

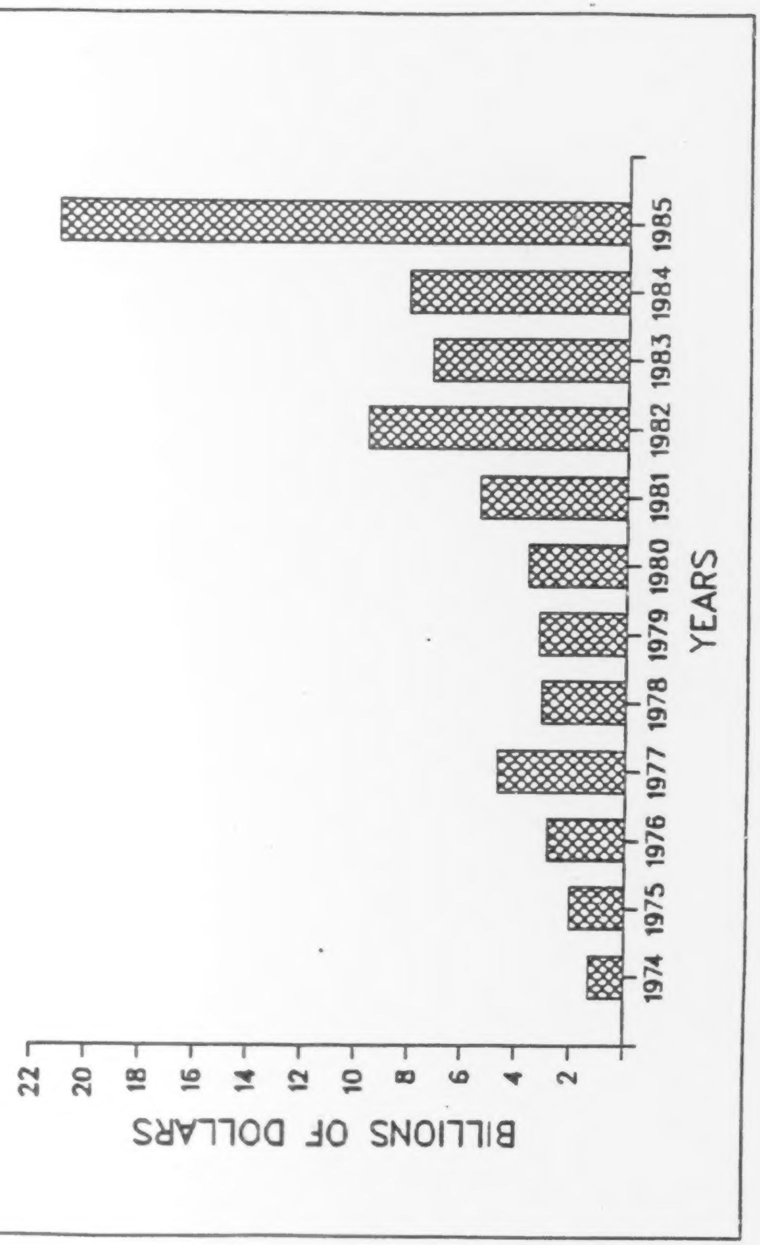
LABOR PORTION X WAGE INDEX + NONLABOR PORTION CAPITAL & NONCAPITAL

BLENDING PERCENTAGE FOR THE TRANSITION PERIOD

	NATIONAL RATE PORTION	HSP DEPRECIATION INTEREST PORTION	HSP RETURN ON EQUITY INTEREST OFFSET PORTION
FY 1987	20%	80%	75%
FY 1988	40%	60%	50%
FY 1989	60%	40%	25%
FY 1990	80%	20%	0%
FY 1991	100%	0%	0%

TRANSITION PAYMENT METHOD


CURRENT PAYMENT
=
URBAN
RURAL
CURRENT LABOR AND NONLABOR
X
DRG WEIGHT
X
INDIRECT MEDICAL EDUCATION
CAPITAL PAYMENT 1
=
URBAN
RURAL
BLEND %
X
CAPITAL NATIONAL AMOUNT
X
DRG WEIGHT
LESSER OF:
CAPITAL PAYMENT 2
=
BLEND %
X
HOSPITAL SPECIFIC DEPRECIATE & INTEREST
+
BLEND %
X
HOSPITAL SPECIFIC ROE & INTEREST OFFSETS
OR
BLEND %
X
HOSPITAL SPECIFIC AUDITED COSTS



HOSPITAL BOND ISSUES
(excludes refinancing)

MSA OCCUPANCY RATES - 1984

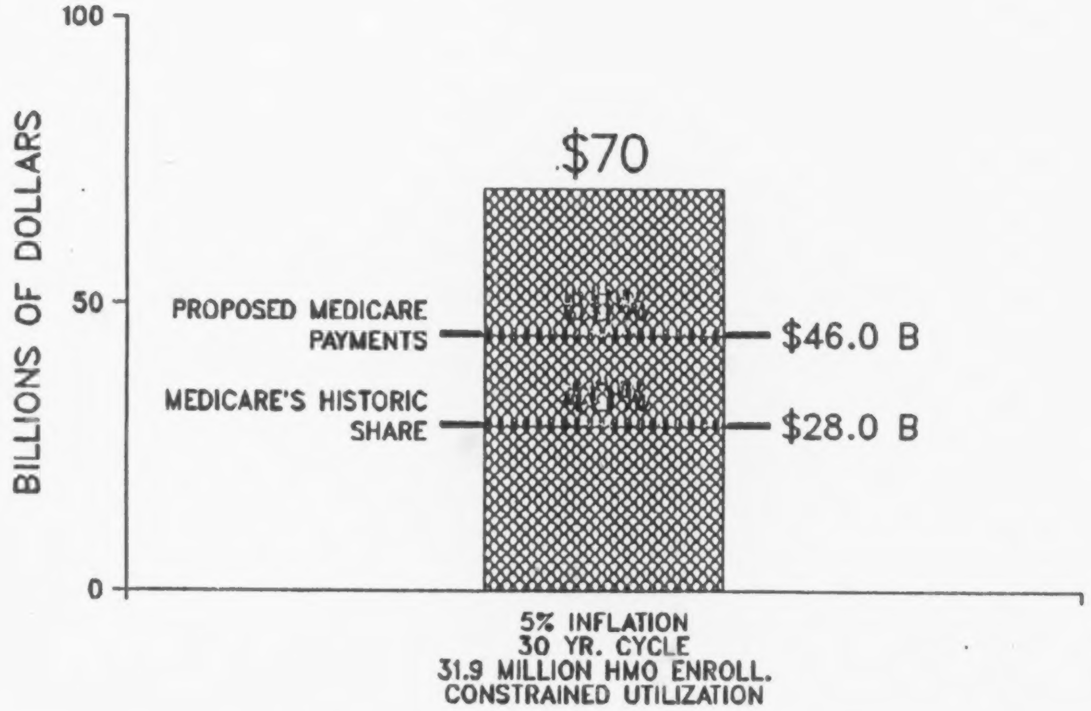
(3103 Hospitals)

	ACTUAL	ADJUSTED*
UNDER 60%	22 (6.71%)	35 (10.67%)
60 - 70%	149 (45.43%)	180 (54.88%)
70 - 80%	129 (39.33%)	107 (32.62%)
80+	28 (8.54%)	6 (1.83%)
SUM	328 100.00%	328 100.00%

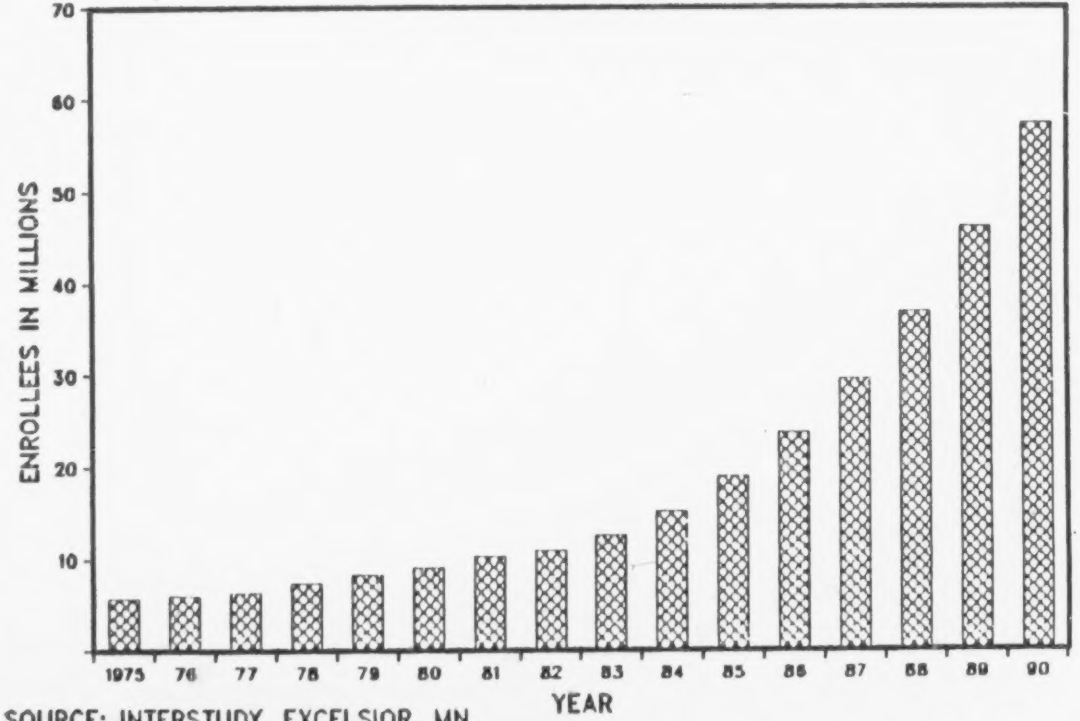
* Adjusted length of stay

HP310-1486-3P

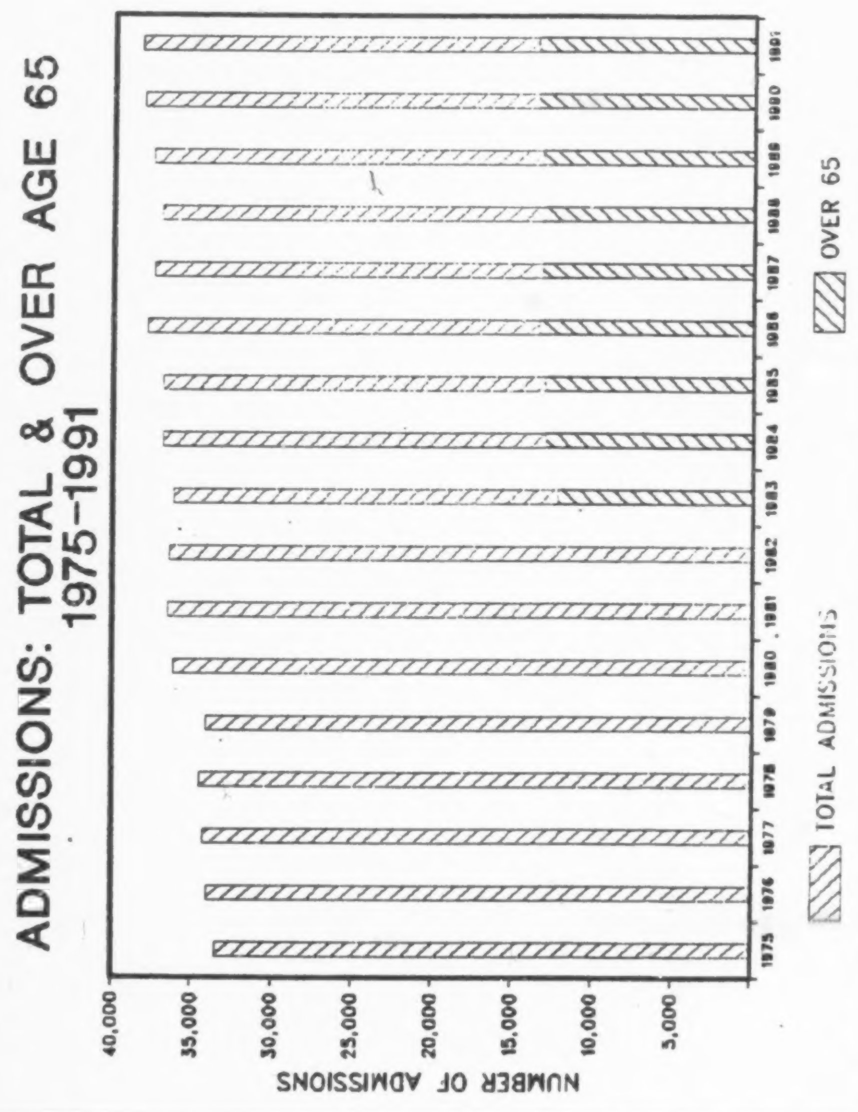
HOSPITAL CAPITAL REQUIREMENTS 1986-1995

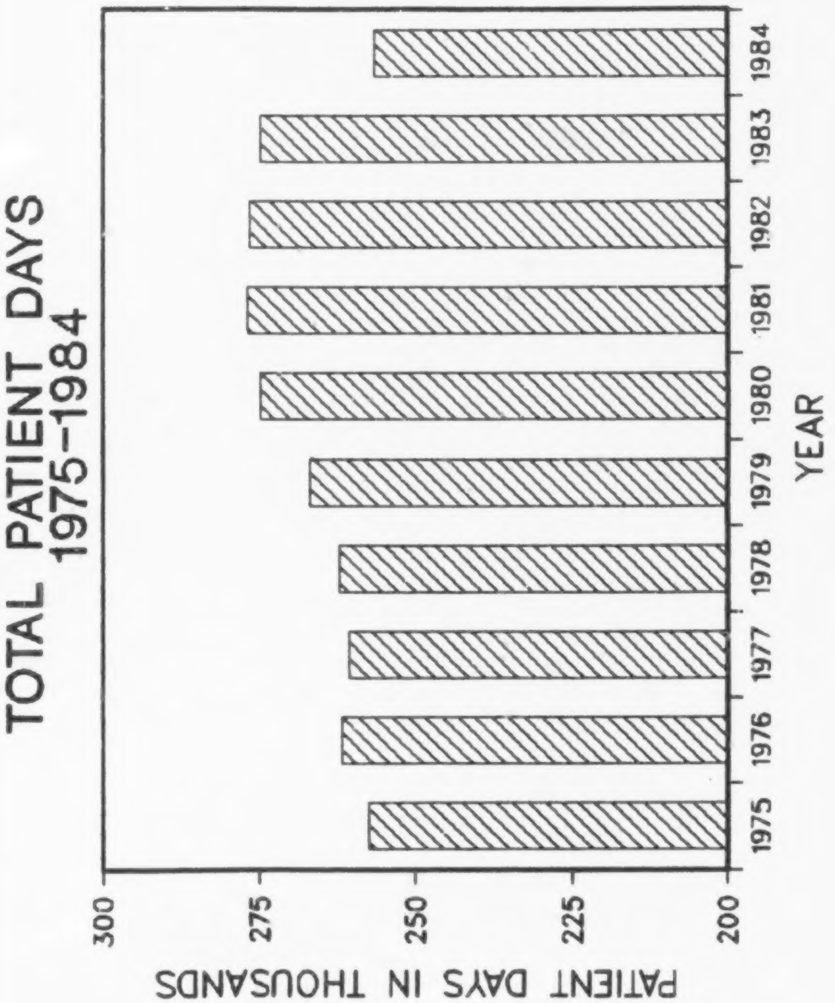


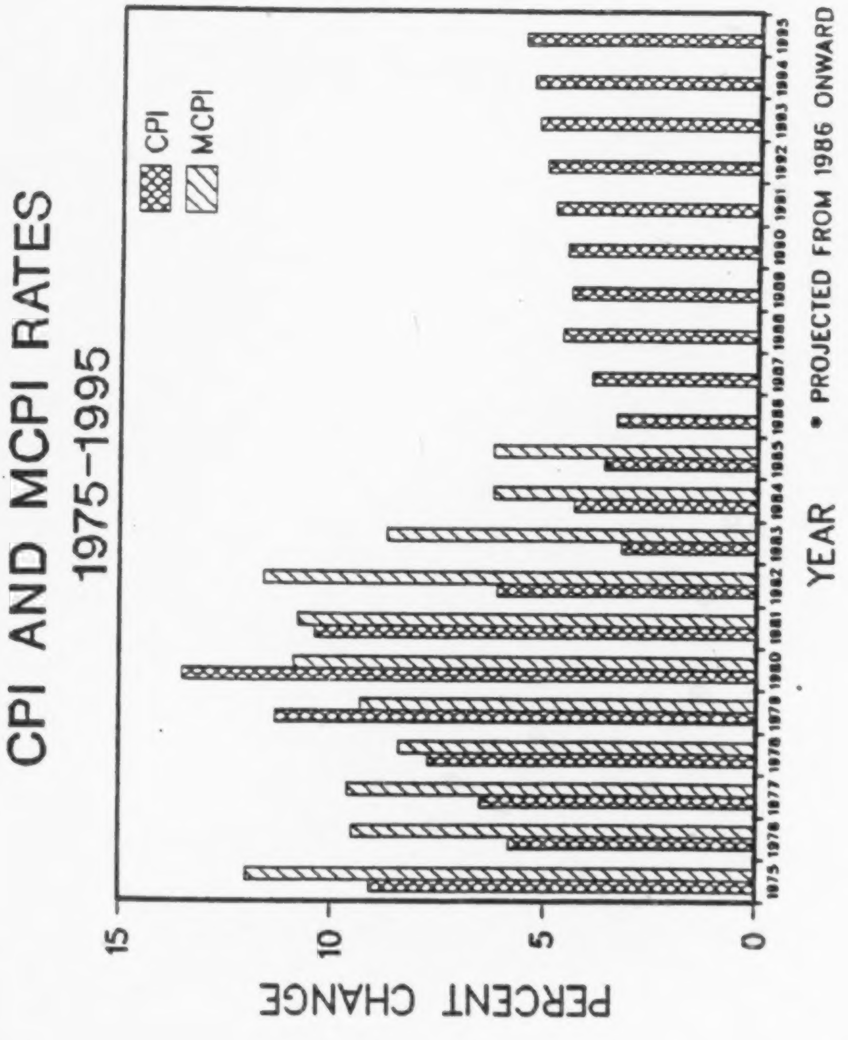
GROWTH IN HMO ENROLLMENT
1975-1990



SOURCE: INTERSTUDY, EXCELSIOR, MN.
NUMBERS FOR 1986 ONWARD ARE ESTIMATES.


ADMISSIONS: TOTAL & OVER AGE 65
1975-1991
NUMBER OF ADMISSIONS
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
1985
1986
1987
1988
1989
1990
1991
TOTAL ADMISSIONS
OVER 65


TOTAL PATIENT DAYS
1975-1984
PATIENT DAYS IN THOUSANDS
300
275
250
225
200
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
YEAR


CPI AND MCPI RATES
1975-1995
CPI
MCPI
PERCENT CHANGE
15
10
5
0
1975 1976 1977 1978 1979 1980 1981 1982 1983 1984 1985 1986 1987 1988 1989 1990 1991 1992 1993 1994 1995
YEAR
* PROJECTED FROM 1986 ONWARD

RECOMMENDATION FOR INCORPORATING CAPITAL RELATED EXPENSES INTO THE MEDICARE PERSPECTIVE PAYMENT SYSTEM

In developing our mandated report to Congress regarding inpatient capital-related expenses, the Department of Health and Human Services analyzed several methods for incorporating capital-related expenses into the Medicare prospective payment system. One method, cost-based reimbursement with or without limits and controls, would continue to reimburse capital costs independently of the basic DRG payment methodology. The other approach, the average-rate method, would pay for capital prospectively. The latter method requires decisions regarding the payment mechanism, the level and distribution of payments, the structure of a transition period and the relationship of the capital payment to the current prospective payment system.

Although the Congress requested only a study of methods for incorporating payments for capital into the prospective payment system, we chose to examine a broad range of options for making capital payments to hospitals. From our analysis, we have concluded that most of the possible methods for paying hospitals for capital related expenses are not consistent with the goals of administrative simplicity, flexibility for hospital management, predictability of payment, and incentives for efficiency.

Based on analyses conducted pursuant to our study contract with ICF, Inc., using their Hospital Investment Simulation Model, we believe that amounts for capital can be averaged into the DRG payments. We have concluded that such a change in Medicare reimbursement policy for hospital capital would be a major step toward a more rational and less interventionist role for government as the major payer for hospital services. It is also a necessary next step for attaining the efficiency and quality goals of the prospective payment system.

This chapter details conceptual specifications for incorporating Medicare payment for capital into DRG payments. In the course of the decisionmaking process, we will continue to refine and perfect our approach. In some cases, the process may significantly modify these conceptual specifications. Similarly, the Department will be refining preliminary estimates contained in this report, which will be subject to detailed actuarial review.

As discussed in the previous chapter, cost reimbursement for capital has several undesirable attributes. In reimbursing an individual hospital for depreciation and interest, Medicare reimburses hospitals on the basis of past investment. This policy insulates hospitals from the financial risk of a poorly conceived or poorly timed investment.

For example, Medicare subsidizes the fixed costs of hospitals associated with excess and unused capacity. In effect, this subsidy of total fixed costs has helped maintain the financial solvency of hospitals that suffer from very low occupancy levels in geographical areas with a significant number of excess beds. In general, if a hospital's fixed costs or overall debt service expenses are being covered, it can financially survive prolonged periods of low occupancy, provided its staffing and other operating costs are aligned with its actual occupancy level, and not its total bed capacity. In competitive markets and areas with good access to hospital care, Medicare has been inappropriately subsidizing underutilized hospitals that simply are not able to attain a reasonable market share. This subsidy as been estimated by Medicare studies to range from $8,400 to $27,900 per bed per year, depending on the staffing level associated with the bed. These estimates came from Mark Pauly's article in Business and Health ("Policy Lessons from Studying Hospital Costs", September 1985), and from conversations with Mark Pauly.

Cost based reimbursement also produces enormous inequities in the ability of different classes of hospitals to make capital investments because reimbursement to hospitals is not directly related to demand for service. Since payments are based on each hospital's financing costs for capital, on the value of its current assets and on its total bed capacity, there are large disparities in Medicare payments for capital to different classes of hospitals for reasons unrelated to the care of Medicare patients. Medicare makes high capital payments, on average, to many hospitals primarily because those hospitals in the past have been credit-worthy, have had good access to capital markets, and have used that access to invest heavily in capital inputs. On the other hand, Medicare makes low capital payments to hospitals such as large public hospitals and to other hospitals which are less able to obtain financing for capital investment.

In sum, the current cost pass-through for capital displays the same problems and liabilities as did the pre-prospective payment system for operating costs. It provides the wrong kind of incentives for hospital managers; it requires detailed cost reporting; and it makes payments that are difficult to predict for Federal budget purposes.

Medicare's cost reimbursement system subsidizes hospitals which are not economically viable and which are not needed for patient care. These capital subsidies can better be used for patient care in economically viable hospitals. In this time of scarce resources, Medicare cannot continue a policy that subsidizes inefficient economic units that are not needed to maintain access to high quality care. Further, the Federal government cannot sustain a policy that rewards hospitals based on their ability to access capital markets, instead of rewarding them for the provision of care to Medicare beneficiaries.

Our proposed payment system would break the link which relates Medicare capital payments to the value of a hospital's current assets rather than to its Medicare volume and case-mix. Currently, assuming the identical Medicare utilization, a high capital asset base generates high capital-related revenues, while a low capital asset base generates low capital-related revenues. With our policy, payment for capital would be linked directly to absolute Medicare volume (i.e., discharges) rather than Medicare's relative share regardless of total capacity.

RECOMMENDATION

The Department's recommendation is based on our conclusion that the hospital industry is currently experiencing a significant and costly excess capacity. There are currently 4.5 beds per 1,000 population nation wide and many areas are experiencing significantly higher rates. Current demand for beds is only 2.7-2.9 per 1,000 population and is expected to decline below this rate with the continued growth in alternative site providers, such as ambulatory surgery centers.

Excess beds including the associated staff and equipment greatly decrease the efficiency of the care provided. In fact, excess capacity may tempt hospitals to provide more care than is medically necessary thereby increasing the risk of an adverse medical outcome.

In order to be a prudent purchaser of hospital services, Medicare should correct for the inefficiencies created by its current reimbursement policy, but it must do so without reducing either the quality of care provided or access to that care for Medicare beneficiaries.

As requested, we recommend to the Congress a proposal that would accomplish the following:

- Establish an all-inclusive prospective payment amount that would pay hospitals an average amount per Medicare discharge. This payment amount would not distinguish between payments for capital and operating expenses and would be neutral with respect to hospitals' prior success or failure at accessing capital markets.

- Reduce Medicare payments to hospitals for capital by establishing a national payment amount that does not include payments for return on equity for investor owned hospitals and payments to hospitals for interest on funded depreciation.

- Provide for an adequate transition period from current cost-based reimbursement to the prospective payment system in order to allow hospitals the necessary time to adjust to the new payment system while assuring that hospitals do not over-invest during the transition.

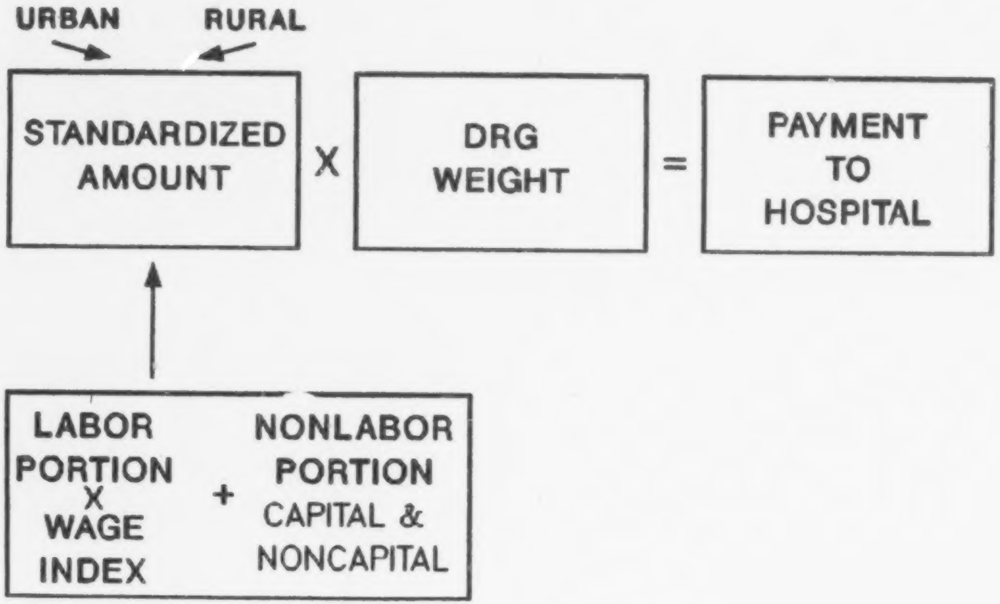
- As appropriate extend special rules regarding capital payments to hospitals that are subject to these rules under the prospective payment system for operating costs.

OUTLINE OF THE RECOMMENDED POLICY

Mechanism. Build into the non-labor component of the standardized payment amounts for rural and urban hospitals (separately) an amount for capital. This amount combined with the current non-labor amount will constitute the standardized payment amount for Medicare PPS hospitals. After inclusion in the standardized amount, capital payments will be indistinguishable from other non-labor payments. Table 1 depicts how the payment mechanism would operate when fully implemented.

TABLE 1

PAYMENT CALCULATION


URBAN
RURAL
STANDARDIZED AMOUNT
X
DRG WEIGHT
=
PAYMENT TO HOSPITAL
LABOR PORTION X WAGE INDEX
+
NONLABOR PORTION CAPITAL & NONCAPITAL

implemented.

Payment Levels. During the transition, separate standardized capital payment amounts will be established for rural and urban hospitals, as designated by current PPS regulation. The separate rates for urban and rural hospitals would be developed in manner which is consistent with current PPS policy for operating expenses. These standardized payment amounts for fiscal year 1987, the first transition year, will be established from 1983 audited cost report amounts updated to 1986 by a capital market basket for fiscal years 1984, 1985, and 1986. Aggregate return on equity and interest offset, chief among them interest offsets on funded depreciation amounts will be excluded from these computed standardized amounts.

Transition. The transition period is designed to fully implement an all inclusive prospective rate for Medicare by 1991. The transition involves separate schedules for phasing out hospital specific payments for depreciation and interest, and for return on equity and interest offsets on funded depreciation. Payment levels for depreciation and interest, and for Return on Equity (ROE) and Interest Offsets (IO) will be established for each hospital based on audited cost reports. During the transition, these two unique HSP amounts will be updated from year to year after 1986 using the actual hospital capital market basket. In each year of the transition, they will constitute a reasonable cost growth limit on each hospital's costs. Hospital will be paid the lesser of the sum of their two payment amounts, or their actual audited capital costs, after the appropriate blend proportions have been applied.

The setting of reasonable cost limits for hospitals has long been a Medicare tradition. Section 223-type limits were imposed elsewhere when cost reimbursement growth was as large as 15 to

20%. There is now evidence that capital expenditures have increased substantially in recent years, while occupancy rates have declined. It now seems apparent that in order to promote efficiency in hospital investment management, 223-type limits are an appropriate mechanism.

The blending proportions during transition are depicted below:

Table 2
Blending Percentage for the Transition Period

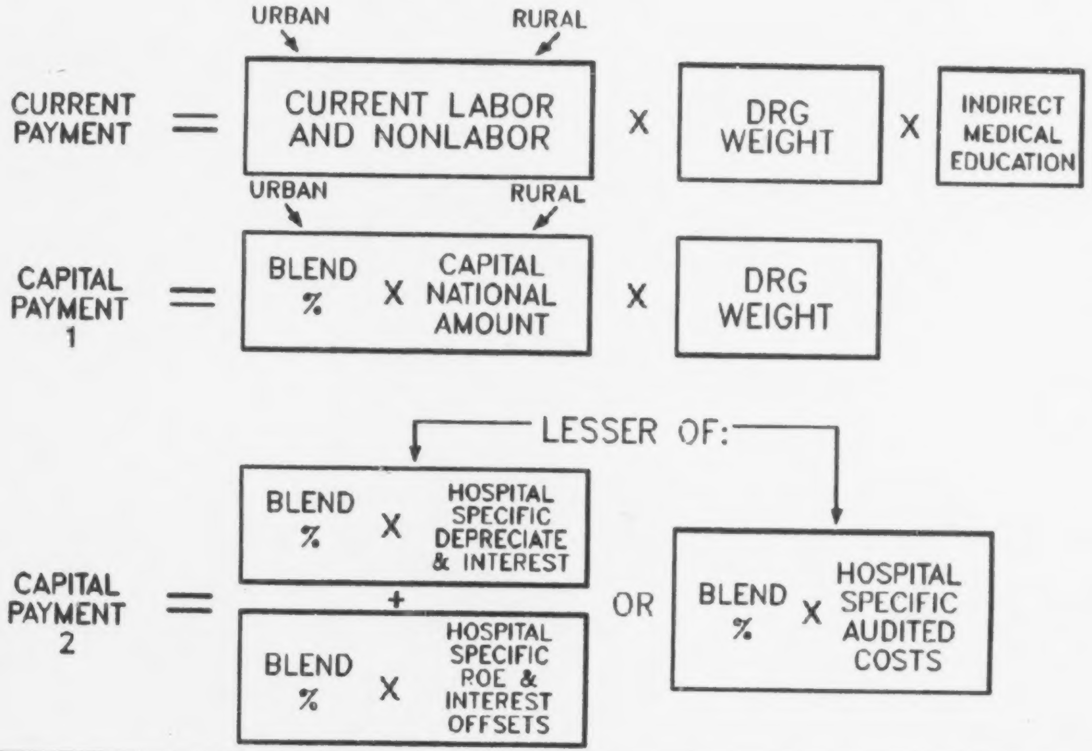
	National Rate Portion	HSP Depreciation Interest Portion	HSP Return on Equity Interest Offset Portion
FY 1987	20%	80%	75%
FY 1988	40%	60%	50%
FY 1989	60%	40%	25%
FY 1990	80%	20%	0%
FY 1991	100%	0%	0%

For example, hospitals in 1987 will receive 75% of their ROE-IO plus 80% of their 1986 depreciation and interest net of offsets for funded depreciation trended forward, (or 80% of the actual amount if it is less) plus 20% of the national rate. In 1991, they will receive a single payment for each discharge equal to the sum of the national rates for capital and for operating costs. Table 3 depicts graphically how the transition period would work.

In FY 1986, hospitals will be paid their actual costs for Depreciation, Interest, ROE, and Interest Offsets under the current reasonable capital cost procedures. The transition to the national rate will be implemented beginning October 1986 (FY

TABLE 3

TRANSITION PAYMENT METHOD


CURRENT PAYMENT
=
URBAN
RURAL
CURRENT LABOR AND NONLABOR
X
DRG WEIGHT
X
INDIRECT MEDICAL EDUCATION
CAPITAL PAYMENT 1
=
URBAN
RURAL
BLEND %
X
CAPITAL NATIONAL AMOUNT
X
DRG WEIGHT
LESSER OF:
CAPITAL PAYMENT 2
=
BLEND %
X
HOSPITAL SPECIFIC DEPRECIATE & INTEREST
+
BLEND %
X
HOSPITAL SPECIFIC ROE & INTEREST OFFSETS
OR
BLEND %
X
HOSPITAL SPECIFIC AUDITED COSTS

1987) according to each hospital's accounting year.

Distribution. The applicable DRG weights for the year in question will be used. These weights are based on hospital charges and on average reflect each hospital's estimate of the relative operating and capital resource consumption associated with each Medicare service, discounted or enhanced by the market value of the service category.

Update Factor. A capital component will be incorporated into the hospital market basket. The PPS standardized amounts will be updated during the transition and subsequent years by the DRG update factor as determined by the Secretary of HHS. The Secretary will take into consideration the capital needs of the hospital industry when establishing this factor. The HSP amounts during the transition will be updated each year by the capital component of the hospital market basket. Capital related items will be incorporated into the Medicare hospital market basket. Disaggregation of the standardized amounts will be accomplished as it is under current policy. The relative labor and nonlabor proportions found in the market basket will be applied to the standardized amounts to produce the separate labor and nonlabor amounts used to make PPS payments to hospitals.

Senator **Durenberger**. Our next panel consists of Jack W. Owen, executive vice president, American Hospital Association; Michael D. Bromberg, executive director of the Federation of American Health Systems; William J. Cox, vice president, Catholic Health Association; and Larry S. Gage, president, National Association of Public Hospitals.

Gentlemen, we welcome all four of you. Your statements will be made part of the record.

And we will begin with Jack Owen.

STATEMENT OF JACK W. OWEN, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC

Mr. **Owen**. Thank you, Mr. Chairman. It is a pleasure to be here today, and it is also a pleasure to comment on Senate bill 2121 and to hear your comments that this should be a legislative solution rather than a regulatory one. And we support that fully.

I have submitted data for the record, and I would just like to take my short time to summarize what I think are some important points, if that is acceptable to you.

We feel strongly that this should be a legislative solution because the HHS was asked for a study which has been reported back today, and it seemed to be the intent of Congress at the time that the prospective payment system was passed that we would come back and have a chance to debate the capital issue, which is important to all of us. And this gives us a chance for dialogue.

We have looked at the administrative approach. What they have done is very good from the standpoint of how they have approached it. However, it is completely unacceptable. It looks to us like a budget-cutting tool more so than a way to get a proper amount of capital to the health care field.

If the cutbacks and the reductions in capital are carried out by the administration, we see some defaulting likely to occur in some bonds, and we think this is going to create problems not only for the health care field but for the financial institutions as well.

Hospitals can make operating changes and have made them. And you know that as well as anybody because you have been very much behind the changes that have occurred. But we cannot make the changes in capital. We have commitments that go back in the 1970's, the 1980's, and you cannot cut back on equipment and you cannot lay off machines or lay off pieces of building like you can employees. So that the changes that we have made in the operations have been dramatic, but we are not as able to make the changes in capital. Can in the future, and should. And we do not argue that point. But what has been committed, we are stuck with.

Your bill and Senator Quayle's bill, we think, moves much closer to what we are looking for. I think the length of the transition is certainly much better. It provides opportunity, we think, to meet some of those obligations. But we still have some problems with that as well, and we hope to continue dialog with you. Mostly where you start in your base for your capital.

The long-term savings that Senator Quayle talked about are there. And I think they should be there. The question that we have is can we take those savings out of the commitments that we already have, and we do not think we can.

Hospitals must receive capital payments adequate to meet these commitments. Certainly, anything that was committed before April 1, 1983, were done under the auspices of the Government going to pay for that. There was no warnings, no indication, to hospitals as they made their long-term commitments that anything would change. And so those commitments were made.

The Government is setting the price at the present time. It is not a question of the hospital setting the price to include capital. And if you are going to set the price, it certainly appears to us that that price has to reflect the fact that those commitments that were made prior to 1983 have got to include the full cost of that capital.

Payment policy must be phased in over a period long enough to assure adequate fair capital payments. We would like to see a 10-year phasein. It appears to us that that would take care of about 90 percent of the problems that might occur in the hospital field. Certainly, your bill with 7 years is much better than the 4 years that the administration has, and we applaud you for looking in that direction. We hope we can encourage you to add a couple more years to that bill and make it even a little better.

The update factor as we move into new capital, as we talk from 1987 on, must represent the real world and what is happening out there and not just be a budget-cutting tool.

We have some very good equipment and technology in our health care system, and we need to maintain that. And we are going to have to have a capital update figure that is going to allow that to happen.

In closing, I would just like to make one comment on the tax-exempt bond issue that was brought up. Certainly as you looked at that chart and you saw that large increase in tax-exempt bonds in 1985, it makes it look like the hospitals have gone out and done something that is terribly wrong.

Our figures show that 41 percent of the tax-exempt bonds purchased or sold in 1985 went for refinancing.

Senator **Durenberger**. 41?

Mr. **Owen**. 41 percent. And we have those figures. And I made them available to the House Ways and Means Committee. I didn't bring them this morning. I didn't think it would come up, but I have them available if you want.

If hospitals had not done that, I think in 1986 or 1987 you would be back at us saying why didn't you reduce the rates when you had the chance. So we cannot win for losing in a case like this.

I might just add that since January 1 there have been no tax-exempt bonds sold so it was the market itself and knowing what was happening with the Tax Code that created the problem.

And I would just like to finish by saying that the capital issue is very important, and I think it is one that has to be looked at very carefully because as you look down the line, if there isn't a proper price, I think there is a constitutional issue that is involved in here that could be taking private property without due process. And I think there has to be a good price.

Thank you very much.

Senator **Durenberger**. Thank you very much, Jack.

[The prepared written statement of Mr. Owen follows:]

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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON FINANCE
ON
MEDICARE REIMBURSEMENT FOR CAPITAL EXPENSES

MARCH 14, 1986

SUMMARY

The American Hospital Association (AHA) believes that any specific plan to change the method by which hospitals are reimbursed for their capital expenditures should be based on the following four principles.

First, hospitals should be reimbursed at a rate adequate to support their current commitments. Hospitals should not be penalized for commitments made before changes in capital reimbursements are imposed.

Second, any new payment policy should be phased in over a period sufficiently long, 10 years at a minimum, so as to assure adequate and fair capital payments to meet individual institutions' needs.

Third, the amount of capital to be incorporated into prices must reflect current spending levels. The base year should be the most recent year for which data are available, and updated to reflect real increases in capital costs.

Fourth, any changes made in capital reimbursement policy must be made by Congress rather than by the Administration through regulation. The Administration's proposal for capital reimbursement, insofar as it has been revealed, is based simply on achieving short-term budget savings rather than on establishing sound policy.

INTRODUCTION

On behalf of its 6,100 institutional members, the American Hospital Association welcomes this opportunity to comment on the issue of Medicare capital reimbursement. AHA particularly appreciates the interest that Congress has shown in this issue and its willingness to find a legislative method of changing the current system.

BACKGROUND

When Congress, in 1983, first considered a Prospective Payment System (PPS) for the Medicare program, it understood that capital costs were significantly different from operating costs. While it devised and put into law a new incentive system to pay hospitals for their operating costs under Medicare, it set aside any decisions on capital payments until October, 1986, and directed the Department of Health and Human Services (HHS) to study the issue and report back by October, 1984. HHS has not yet delievered the congressionally-mandated study, and has instead proposed as part of its Fiscal Year 1987 budget the incorporation of Medicare payments for capital into PPS.

CURRENT COMMITMENTS

A key issue that Congress should recognize is the nature of current capital commitments. The time between deciding to replace a plant and actually putting it into service easily can be from three to five years. Funding mechanisms such as bonds and mortgage funding are long-term commitments obligating hospitals for 20 to 30 years. Major equipment purchases have a life of 10 or more years. When these commitments were made, hospital managers properly counted on a certain level of reimbursement from Medicare to honor the Medicare portion of these debts. The ability of hospitals to repay existing debts will be severely hampered if the level of capital reimbursement is dramatically reduced while their debt service costs remain the same. Any payment scheme accepted by Congress must recognize these prior commitments made by hospitals.

TRANSITION

When considering major changes in the way in which the Medicare program pays for capital costs, the structure of these costs must be fully understood. Capital costs can vary tremendously over time for a particular hospital, depending on the overall average level of investment in capital or on whether it has recently undertaken a major investment. High capital costs in any given period may simply reflect a recent major investment and have no relation to whether a hospital is operated efficiently. Capital costs are long term in nature and follow an extended cycle unique to each hospital. In general, this capital cycle is 20 years, with a 10-year mid-life. Therefore, to avoid major disruption in hospital capital financing programs, the payment system should be phased in over a period of at least 10 years. A phase-in period that is sympathetic to current hospital capital cycles will help ensure that capital policy is adequate and fair.

While hospital operating costs can be altered relatively easily over the short term, managers cannot make short-term decisions to reduce capital outlays. One cannot reduce work hours or lay off equipment as can be done with staff. Simply changing resource use does not relieve payment of debt.

Only decisions that play out over time can reduce capital costs. Movement from a cost pass-through reimbursement method to a consolidated price payment method constitutes a major change in Medicare payment policy--so major, in fact, that the administrative and incentive benefits realized from such a change can easily be negated if an adequate transition mechanism is not included. Hospitals making major capital expenditures incur financial obligations over extended periods of time. Absent an adequate transition mechanism, such hospitals are unlikely to be able to satisfy these obligations and future access to capital will be jeopardized.

The transition mechanism should be structured to recognize and account for the needs of those hospitals that have recently incurred significant costs for facilities not yet in use, or that may soon incur such obligations because of code and standards compliance requirements and capital requirements associated with increases in community service needs.

Splitting payments for moveable equipment and fixed plant and equipment would not compensate for a short transition. The AHA has significant concerns about the feasibility of separating moveable from fixed capital due to the complexity added to the existing payment system and the lack of current data pertaining to the differentiation between fixed and moveable assets. Separating only fixed assets for cost pass-through or a long transition would invite a continued role for health planning or 1122 regulation.

ADEQUACY OF CAPITAL PAYMENTS

The AHA's fundamental concern is that capital payments be adequate to meet hospitals' existing and future capital needs. Current spending levels should be used as a starting point, and if incentives to reduce future growth are established, they should be effective only for future years.

To reflect real hospital capital costs, when devising a formula for reimbursement, the most recent base year possible should be used. In addition, all capital costs that have traditionally been reimbursed under long-standing Medicare policy should be a part of that base. To remove these costs from the base would penalize hospitals unfairly and limit their ability to meet existing obligations.

Beyond initially incorporating capital payments at current spending levels, in future years the consolidated Medicare price should be updated annually using an expanded hospital market basket that includes weights and factors pertaining to hospital capital costs.

Finally, an explicit, minimum technology improvement factor should be applied in annually updating consolidated prices to recognize increases in both capital and operating costs associated with certain types of medical technology improvements.

ADMINISTRATION PROPOSAL

The Administration's budget calls for incorporation of capital payments into PPS through a regulatory proposal, that, in its current, draft form, violates all the principles established by AHA for a workable capital plan.

HHS plans a four-year transition, considerably shorter than the 10-year transition considered essential by the hospital industry. After the transition is complete, the HHS plan would result in payments based on 1983 costs, which fail to adequately recognize the changes in capital costs over the past three years and the life of the transition. The proposal also eliminates from the 1983 base several important elements, including return on equity, interest on funded depreciation accounts, and donated assets. These adjustments erode the base-year funding pool solely for budgetary reasons. The capital update factor, which would be used to project 1983 actual costs to 1987 levels, bears absolutely no relationship to the actual increase in capital costs over this period and underscores the clear intent of HHS to use this formula to reduce budget outlays.

The HHS draft proposal, expected to be published in June, also contains a variety of caps on the hospital-specific portion of the payment formula restricting growth to 1986 levels. Such caps again are proposed solely for budgetary reasons and fail to anticipate that some hospitals must increase capitalization for public health reasons.

It is clear that if this nation's health care delivery system is to continue to have the ability and capacity to serve the Medicare population and others, we must look to Congress for a balanced solution to the problem of capital.

FAIR DEAL CAPITAL PAYMENT ACT

Senators Durenberger and Quayle have introduced legislation, S.2121, to incorporate capital payments into PPS. Under this legislation, over a seven-year transition period, Medicare hospital reimbursements for capital would consist of blended proportions of a hospital-specific capital payment pass-through, and a national standardized average capital payment amount. The base year for calculating the national capital rate would be the most recent fiscal year for which adequate national data are available. The national rate would be adjusted to offset interest expense with interest income, eliminate return on equity, reflect local construction costs associated with depreciation of physical plant, and reflect changes in the cost of capital since the base year.

While the AHA strongly supports a legislative solution to the problem of changing capital reimbursement, the mechanics of S.2121 present significant problems. Of greatest concern is the calculation of the national payment amount. The AHA anticipates that the method proposed will result in capital payments to hospitals that fall substantially short of actual capital costs.

Adjustments made to Medicare average capital cost-per-discharge in the base year to exclude return on equity and to offset capital-related interest expense with interest income from all sources could result in reducing the base an estimated 24 percent.

The update factors that would be used to bring the base forward to FY 1987 do not reflect the actual increases in capital expenses during this time period, since they would account only for price changes and not volume changes. This could result in updates as much or more than three times lower than what would be required to reflect actual hospital capital expense increases.

There has been approximately a 7 percent decrease in Medicare admissions since 1983, the likely base year. Since the national capital add-on payment may be based on the FY 1983 Medicare average capital cost-per-discharge, it will not reflect or compensate for this reduction. In order to compensate, the base would have to be redefined as FY 1983 Medicare average capital cost per FY 1986 or FY 1987 discharge.

After the transition under S.2121, AHA estimates that hospitals may experience as much as a 30-percent to 50-percent deficit in Medicare capital payments. Even with the seven-year transition--three years short of the 10 years supported by the AHA--hospitals with high capital costs will experience major shortfalls in capital payments. In particular, hospitals adversely affected would be those that have obligated, but not yet expensed, major capital expenditures prior to the incorporation date and those that must incur major, non-discretionary capital expenditures during the transition to satisfy accreditation or licensure standards.

Other potential problems with the bill include inadequate definition of the mechanism that the Secretary of HHS would use in estimating the capital payment ratios, inadequate assurance of timeliness of retroactive adjustments in capital payments based on corrections of those estimates, and inadequate provision for updating the national capital add-on payment on an ongoing basis after the transition. While the bill indicates that the national add-on payment would be updated after the transition by the same increases applied to the DRG standardized amounts, there is no provision to include consideration of capital expense increases.

While the AHA seeks a legislative approach to capital incorporation, the Durenberger/Quayle proposal differs little from the Administration's capital proposal and provides too much discretionary power to the Secretary of HHS to determine the national capital rate update amount. However, S.2121 does provide a longer transition period to the national rate than does the

Administration plan and it recognizes the need for a high percentage of hospital-specific costs in the payment formula in the early years of this period.

HEALTH PLANNING

As a final point, the AHA believes that a federal role in state capital expenditure regulation is no longer necessary. Whether or not Medicare capital payments are incorporated into DRG prices, recent moderation in hospital capital spending demonstrates that hospitals are responding to changes in health services utilization and to the efficiency incentives inherent in Medicare and other payment systems. Rates of increase of hospital capital expenses for community hospital have been lower in 1983-1985 than they were in 1981 and 1982 (see attached table). Most notably, the change in capital expenses in the first 11 months of 1985 compared to those in the first 11 months of 1984 is 12.2 percent, over 6 percentage points lower than the rate of increase in capital expenses in 1984 compared to those in 1983.

The percent change for capital expenses in the quarter ending November 1985 compared to those in the quarter ending November 1984 is 10.0 percent, an even sharper decline in the rate of increase of hospital capital expense. Given this clear indication of moderation in hospital capital spending, federal sponsorship of the Section 1122 review program and involvement in state CON programs should be terminated. In addition, any attempt by HHS to impose Section 1122 requirements should be blocked by Congress.

CONCLUSION

The AHA believes that if capital payments are to be incorporated into DRG prices, capital and aggregate DRG payments must be adequate and equitable from the standpoint of the individual hospital.

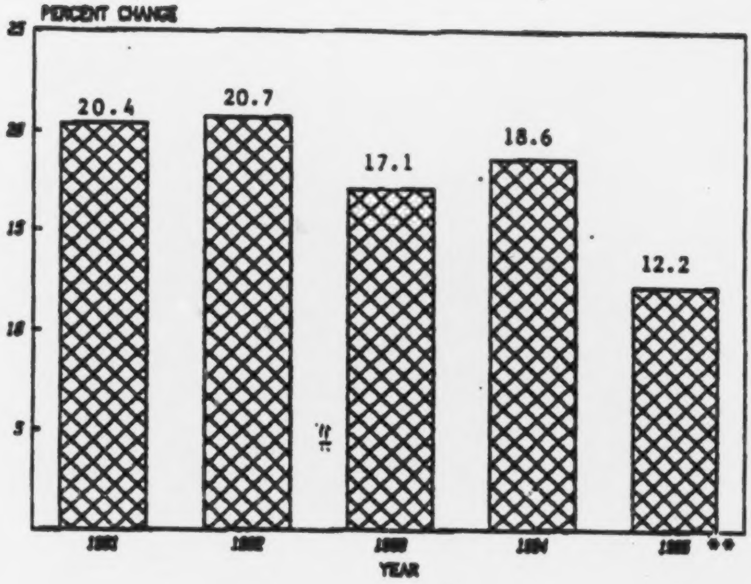
Congress should establish any new payment policy and, if it is unable to agree by the October 1, 1986 deadline, should continue the current payment system through a short-term legislative extension until permanent legislation is enacted into law.

Any new payment system should be phased in over at least 10 years, recognize and account for hospitals' current commitments, and be based on the most recent costs and reimbursement policy possible.

The AHA is particularly concerned that, in the current federal fiscal environment, changes in Medicare capital payment policies and methods will be used as a budget deficit reduction device, with catastrophic financial impacts on those hospitals that have recently incurred or may soon incur necessary major capital expenditures. In view of the substantial reliance of hospitals on debt sources of capital, the use of capital payment to help achieve deficit reduction goals could substantially affect investor confidence in hospital industry investments, thus unnecessarily leading to an industrywide increase in the cost of capital.

Finally, AHA believes that, beyond the issue of capital payment, several fundamental concerns with the DRG system itself must be addressed in order to assure that aggregate Medicare payments to hospitals are adequate and equitable and, thereby, that Medicare beneficiaries are well-served.

RATE OF INCREASE OF HOSPITAL CAPITAL EXPENSES* FOR COMMUNITY HOSPITALS
1981 - 1985**



* DEPRECIATION AND INTEREST

** FOR 1985, FIGURES REPRESENT PERCENT CHANGE FOR THE FIRST 11 MONTHS OF 1985 COMPARED TO THE FIRST 11 MONTHS OF 1984 (NOT LEAP YEAR OR SEASONALLY ADJUSTED). THE PERCENT CHANGE FOR CAPITAL EXPENSES IN THE QUARTER ENDING NOVEMBER 1985 COMPARED TO THOSE IN THE QUARTER ENDING NOVEMBER 1984 IS 10.0 PERCENT, AN EVEN SHARPER DECLINE IN THE RATE OF INCREASE OF HOSPITAL CAPITAL EXPENSES.

SOURCE: AHA NATIONAL HOSPITAL PANEL SURVEY

Senator **Durenberger**. Mr. Bromberg.

STATEMENT OF MICHAEL D. BROMBERG, EXECUTIVE DIRECTOR, FEDERATION OF AMERICAN HEALTH SYSTEMS, WASHINGTON, DC

Mr. **Bromberg**. Thank you, Mr. Chairman. I appreciate this chance to testify, but I agree so much with what Jack said that I think what I will do instead is try to raise a few of the points I have heard on the other side and react to them and submit the statement for the record.

We really make three points in our testimony. The first is that we would urge the Congress to pass legislation as quickly as possible to prohibit the subject being done by regulation. Legally, we cannot understand why the Congress would have gone to the trouble to say that if Congress does not act, 1122 will trigger in, if what Congress really meant to say was if Congress does not act, the Secretary should do whatever he wants by regulation. And I would hope that you would ask for a copy of that legal memo that they told you existed so that we could share it. And if we do some of our own, we will be glad to share them with you.

But I think we are going to get into the situation not only of litigation if this happens, but changing the base line for Gramm-Rudman, if they go ahead with the regulation, and it is really important.

The argument I have heard against this from some sectors seems to be that if Congress did something like that, prohibit regulations, that our industry would not be held to the fire and that there might not be a bill. And I just want to assure you that we are much more worried about Congress not passing a bill and those regulations triggering in, which would be much worse for us. And we pledge our cooperation if it really is a fair deal to work with you on it.

Senator **Durenberger**. I should say that it occurs to me now that last year we did not get around to passing authorizing legislation until today, as I recall. And I think we will be on the floor sometime. We may be on the floor right now or sometime. And I just was shown a small, little item in the Congressional Record that says that we are moving to national averaging on PPS in reconciliation everywhere except the 49 States outside Oregon. [Laughter.]

You may proceed.

Mr. **Bromberg**. Thank you.

The second point we make in our testimony and the one I want to stress the most is that if we are going to have a fair deal, I think we have to think about old capital and protecting it.

Let me start by saying it was very clear—and we certainly supported it a couple of years ago—when we passed prospective payment, the rationale behind it was if you tell hospital managers out there they are going to get a predetermined amount, they can then use their management skills to cut cost and everybody will benefit. And that is why we supported it. You cannot tell them that for capital if they have already obligated it. There is no way a good hospital manager can change his debt obligations that he has committed to in the past.

And for that reason, the rationale of incentives for efficiency and penalties for inefficiency just do not apply to old capital.

Second, this committee and the Congress itself has a history and a tradition in the tax laws which are no different on changes in capital. You never make them retroactive. When you do things like repeal or change investment tax credits, you never penalize a businessman who made a decision 3 years ago based on what the law was and what the message was and what the incentive was at the time. So if this bill is going to be a fair deal, I would hope that you would consider an amendment that would apply it only to prospective capital.

A transition period, even a longer one than the 7 years, even a 10 or a 15, does not help. It helps mitigate, but it certainly does not solve the problem for the manager out there who just signed 4 years ago a 20 year mortgage. It only mitigates harm.

I think the last point we want to make in the testimony, Mr. Chairman, is to say that of all the proposals we have seen, your bill, S. 2121, is clearly a more acceptable approach than the others, clearly much more acceptable than the administration's for many reasons. But we would still be concerned that it not apply to capital obligated in the past. And for that reason, we would urge you to consider an amendment to that effect.

And we thank you for this opportunity to testify.

Thank you.

Senator **Durenberger**. Thank you very much.

[The prepared written statement of Mr. Bromberg follows:]

STATEMENT OF
MICHAEL D. BROMBERG
EXECUTIVE DIRECTOR
FEDERATION OF AMERICAN HEALTH SYSTEMS
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON FINANCE
ON
MEDICARE PAYMENT FOR CAPITAL COSTS
MARCH 14, 1986

The Federation of American Health Systems is the national association of investor-owned hospitals and health systems representing over 1,300 hospitals with over 154,000 beds. Our member hospital management companies also manage under contract more than 300 hospitals owned by others. Investor-owned hospitals in the United States represent approximately 25 percent of all nongovernmental hospitals. In many communities, the investor-owned facilities represent the only hospital serving the population.

We appreciate this opportunity to present our views on capital financing under the Medicare program.

Regulatory vs. Legislative Action

The President's fiscal year 1987 budget proposes including hospital capital payments in the prospective payments system, through regulatory action. We question the statutory authority of the Department of Health and Human Services to take such unilateral action.

The 1983 Medicare Prospective Payment System (PPS) law assumes Congress will pass a capital plan as evidenced by the statutory directive to mandate section 1122 capital expenditure reviews if Congress does not act.

In order to clarify this point and prevent costly, lengthy, and confusing litigation, we urge Congress to immediately pass legislation to make clear that no capital prospective payment plan can be implemented without Congressional approval.

Budget Neutrality

The President's budget calls for savings of $456 million from its capital plan in the first year alone, FY 1987. This is a cut or at best a freeze in capital payments which can only be characterized as a freeze in medical technology or a prohibition against progress in inpatient treatment of illness. That kind of rationing should be debated carefully. There are already signs that private research and development funding is being slowed by manufacturers of medical equipment. They fear that hospitals will not be able to pay for either incurred capital costs or the increased operating costs of new services with Medicare DRG rates not keeping pace with inflation. We urge the Subcommittee to adopt the more realistic definition of budget neutrality - total expenditures which are no more or no less than would have been spent under existing law.

If the Medicare program is unwilling to contribute its fair share toward needed capital improvements in our health system, then Congress should recognize that such improvements constitute "non-covered services" and can be charged to patients.

It is critical that any action on capital should be at the very least budget neutral.

Old Capital

When Congress enacted the Prospective Payment System in 1983, the rationale for the use of prospective rates for all hospitals based on average costs, was that facility managers could lower their operating costs by improving productivity through efficiencies in such areas as labor, supplies, and length of stay. That rationale cannot be applied to capital, particularly capital expenditures already obligated. The payment of some average capital amount to a facility with existing above average debt leaves that hospital manager helpless to do anything to lower those costs.

Similarly under DRG operating rates, lower cost hospitals are rewarded for their presumed efficient management but if hospitals with low capital costs are paid a higher rate based on averages, that can only be regarded as a windfall, not a reward for efficient management.

For these reasons we urge the Subcommittee to treat old, that is existing, capital in a manner similar to current law. This Committee has historically acted in just that manner when passing tax legislation dealing with capital, recognizing that businesses can do nothing to reverse previous decisions obligating capital expenditures.

A transition period for old capital does not remedy this problem, because the fixed obligations run for many years. It merely postpones the inequitable treatment. We therefore urge you to limit any legislation incorporating capital into DRG rates to new capital expenditures.

New Capital

If Congress establishes prospective payment rates for new capital it is essential to assure equitable annual increases which are based on an economic index reflecting changes in capital costs, such as interest rates, construction costs, and technology changes.

This concept of a fair annual rate of increase was recognized with respect to operating costs when the Medicare prospective payment system first was enacted in 1983 but it has been ignored by the Administration and Congress since that time. It is very difficult for hospital managers to believe it will be any different for capital. At the very least any legislation approved by the Subcommittee should restrict the regulatory power of the Department to reduce or freeze capital payment rates and annual increases without Congressional approval.

If old capital is excluded from prospective rates and paid for as under present law, then the issue of the transition period becomes relatively less important; we would, however, urge the new system not begin until October 1, 1987 (FY 1988) to allow adequate time for hospitals to prepare for the switch over to prospective capital payments and the effects.

If old capital is included in the prospective rates the transition period must be long enough to mitigate the harm done to higher than average capital cost hospitals. Any period less than ten years would be inadequate. We would also recommend a weighted transition so that actual or hospital specific costs would be more accurately recognized in the earlier half of the transition period.

There is No Need for Precipitate Action

Part of the sense of urgency to replace cost based payment for capital has come from concern that the continuation of the status quo would set off a capital spending boom. This fear is greatly exaggerated and not supported by experience. The rate of increase in hospital capital spending has declined from over 20% in 1981 to 8.8% in 1984. The 1985 increase is believed to be lower still. We believe the Medicare prospective payment system will restrain capital expenditures beyond the expectations of many policy analysts. The reason is that while capital costs (depreciation, interest and return on equity) are now excluded from Medicare's DRG rates, the operating costs associated with new capital expenditures are not.

If, for example, a hospital purchases a Magnetic Resonance Imager (MRI) machine for $2 million, it will receive Medicare cost reimbursement for the depreciation and interest, but no cost reimbursement for the technician hired to operate the equipment, or the maintenance costs associated with the new service. Unlike the old cost based reimbursement system, a hospital adding a new service such as a burn unit or a coronary care unit will recover capital costs but receive no direct reimbursement for the personnel hired to staff these units. Since every dollar of capital spending produces about 22 cents of annual operating costs on average, the absence of assured reimbursement for capital related operating costs will act as a very real impediment to capital expenditures, especially new, high cost technology. To illustrate, the ratio of operating costs to capital costs for coronary care units ranges from 1.2 to 3.8; ultrasound from .7 to 1.3 (1). Simply put, the new Medicare DRG prospective payment system, which limits hospital reimbursement to a set payment per case by diagnosis regardless of what type or amount of services the hospital provides a patient, has for the first time placed hospitals directly at risk for increased costs due to both operating and capital-related decisions.

Some of these capital-generated operating costs would normally be recovered under an intensity index, but the Medicare

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1) Arthur D. Little, "Development of a Evaluation Methodology for Use in Assessing Data Available to the Certificate of Need (CON) and Health Planning Programs," Department of Health and Human Services, Office of the Assistant Secretary for Health, Contract Number 233-79-4003, April 1982.

prospective payment rates were increased only a net 4.15% in fiscal 1985 and zero percent so far in fiscal year 1986. Since new capital spending generates higher operating costs, but Medicare's payment for operating costs is fixed by diagnosis, there is little incentive to invest in cost increasing technology. These new operating cost restraints which reward cost efficient behavior by hospitals through incentive payments, are sufficiently strong so that hospitals will not find it in their interest to expand high cost acute care capacity. There is a strong incentive to invest in cost reducing technology.

Furthermore, since capital costs are only 7 percent of Medicare reimbursement, even a large increase in capital investment by hospitals far beyond any reasonable expectation would have only a minor impact on overall reimbursement. More importantly, since the 93% of Medicare reimbursement going for operating costs is now controlled through the DRG prospective payment system, the remaining 7% attributable to capital costs has been and will continue to be restrained. Since the status quo would not generate perverse behavior, and since capital costs vary so widely among hospitals, we do not think that there should be a rush to implement a new Medicare capital payment system on October 1, 1986.

Future Hospital Capital Needs

Current hospital stock is aging rapidly and will at some point have to be renovated or replaced, to meet life and safety code requirements, accreditation requirements of the Joint Commission on Accreditation of Hospitals, and to maintain the current quality of healthcare services provided to Medicare patients. Approximately 40 percent of all U.S. hospital beds were built in the 1950's and early 1960's during the prime of the Hill-Burton program. Those beds are now at or nearing an age of thirty years and need major renovation. Such capital replacement will not be possible if hospitals cannot make a profit or generate a surplus. Given the administration's capital proposal, contained in the Fiscal Year 1987 budget, and the restrictions on increases in hospital payment rates under prospective payment, hospitals will not be able to generate capital internally. Even if there were no expansion of the hospital system, these policies would not provide hospitals sufficient income to even maintain their plants.

S.2121 The Fair Deal Capital Payment Act

The "Fair Deal Capital Payment Act", S.2121, introduced by Senator Durenberger presents a much more acceptable approach to Medicare capital payment reform than that proposed by the Administration. This legislation provides a longer transition period of 7 years and would weight that transition more heavily towards a hospital's actual costs in the earlier years. The bill would also repeal Sec. 1122 which would mandate regulation of new capital projects. Such regulation clearly is unnecessary since hospitals currently are at risk for capital decisions generating additional operating costs. Congress has failed to increase payments for operating costs by the actual hospital market basket and a technology factor, since 1984.

While we find many components of the Fair Deal Capital Payment Act vast improvements over the Administration's capital proposal, we are concerned that it still would not adequately reimburse hospitals for capital commitments made prior to any change in the treatment of capital under the Prospective Payments Sytem. We would recommend strongly that the changes in capital payments described in S.2121 be applied prospectively to new capital. We look forward to working with Senator Durenberger and members of this Subcommittee to develop an equitable Medicare capital payment plan for hospitals.

Conclusion

In summary, if the hospital sector is to have adequate capital and if that capital is to be used efficiently, a Medicare prospective payment system must be fair. The Federation of American Health Systems pledges its cooperation to the Department and Congress in efforts to develop a capital prospective rate because we continue to believe that Medicare payments should be totally prospective. A fair Medicare price will restrain all hospital costs, including capital, but an arbitrarily low price will reduce capital spending below what consumers and communities have a right to expect in modern hospital technology and quality of care.

Senator DURENBERGER. Mr. Cox.

STATEMENT OF WILLIAM J. COX, VICE PRESIDENT, GOVERNMENT SERVICES, CATHOLIC HEALTH ASSOCIATION, WASHINGTON, DC

Mr. COX. Mr. Chairman, I too agree with most of what has been said already this morning, and I am just going to elaborate on a few key points.

The Catholic Health Association has been very concerned about the capital issue since the adoption of prospective payment in 1983. And the reason for that is twofold. First, we tend to believe that our hospitals as a group are probably going to do less well under national DRG rates as we move toward those rates. And, second, our hospitals tend to be at the very beginnings of their capital cycles which means that they have got a large volume of fixed costs that they need to deal with and which costs are very sensitive to any capital proposal treatment within the Medicare Program.

Our concerns have been intensified by some of the issues you raised at the opening of this session. That is, the budget-driven atmosphere within which the prospective payment system has been operated. They have been further intensified by Gramm-Rudman-Hollings and the clear prospect of wholly inadequate rates of increase in the PPS payments for the next 5 years. So you can understand, I think, our deep concern about exposing this large volume of fixed cost to a system that has become somewhat arbitrary with respect to its payments to hospitals and to a great deal unpredictable from the hospital point of view.

The administration—my second point would be—and to echo Mike and Jack—that the administration's proposal is wholly unacceptable to the Catholic Hospital community. We have developed, I think, a rather sophisticated methodology that individual hospitals can use to determine the impact of various capital proposals on them to anticipate that impact. And for today's hearings, we ran the numbers on a large midwestern hospital. And I would like to make a couple of points about this facility.

It is widely recognized within the hospital community as being efficiently run. It has made sound business decisions with respect to its capital expenditures. It began planning for the replacement of a 50-year-old facility in 1979, got all of the necessary approvals, and brought that capital on line in 1984.

If the administration's proposal goes into effect, that facility will not make its principal and interest payments. It will be in technical default on its bonds.

I think that this—we do not think that this hospital, having looked at a number of them, is an isolated example. The hospital is probably, as Bill Gradison said over on the House side, the tip of the iceberg. There are some very scary scenarios out there with respect to folding capital into the prospective rate. And we think that the experience of this facility and other facilities argues very strongly for Congress to act immediately to prevent the administration from folding capital into the prospective payment system via the regulatory route.

And I think that would be the strongest point or recommendation that I would like to make this morning.

By way of contrast to the administration's proposal, yours is clearly superior. And we ran the numbers for this midwestern hospital in terms of your proposal, Mr. Chairman, and I am happy to say that the facility would be able to make its principal and interest payments under your approach. However, the 7-year transition probably does not go far enough.

Senator DURENBERGER. They want to make more money?

Mr. COX. Pardon?

Senator DURENBERGER. They want to make more money?

Mr. COX. No. I think they want to meet their capital needs.

Finally, I would like to make one last point, Mr. Chairman, and that is with respect to relating what is going on in tax reform with what is going on in the capital issue. That is to indicate that nonprofit hospitals must continue to have access to advanced refunding. And I know you have recognized, and we commend you for this——

Senator DURENBERGER. I am going to ask each of you to respond on the specific on that particular issue as it relates to the tax-exempt bonds.

Mr. COX. Well, that they should continue to have that access. I know your proposal would allow them to have at least two advanced refundings. But under the State by State per capita caps, our analysis indicates that the advanced refundings have to occur under the caps. New financings will use up most of the money that is available and leave very little available for advanced refunding. So I think that issue needs to be examined very carefully.

And that concludes my testimony.

Senator DURENBERGER. Thank you very much.

[The prepared written statement of Mr. Cox follows:]

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STATEMENT
of the
THE CATHOLIC HEALTH ASSOCIATION
OF THE UNITED STATES

on

PROPOSALS TO INCORPORATE CAPITAL COSTS INTO MEDICARE'S PPS

Presented to
The Subcommittee on Health,
Committee on Finance
United States Senate

by
William C. Cox
Vice President
Division of Government Services

March 14, 1986

Representing almost 900 hospitals and long-term care facilities nationwide.

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Mr. Chairman, and members of the Committee on Finance, I am William J. Cox, Vice President of the Division of Government Services for the Catholic Health Association of the Unites States (CHA). CHA represents 630 Catholic hospitals and 285 long-term care facilities nationwide.

I am grateful for the opportunity to be here today to testify on the subject of incorporating capital costs into Medicare's prospective payment system (PPS). I am also grateful to you, Mr. Chairman, for your leadership and interest in this critical issue.

CHA's Position on Capitol

CHA first enunciated its capital position in April 1984 before the Department of Health and Human Service's National Council on Health Planning and Development. At that time, CHA told the Council that while Catholic hospitals remained open to discussing and evaluating proposals for incorporating capital into PPS, we had not yet seen any capital proposals that would be acceptable to our members. Furthermore, before we would deem a capital proposal acceptable it would have to be demonstrated to be workable and equitable for Catholic hospitals. Finally, we expressed our belief that identifying such a capital proposal would be more difficult than many of us had originally believed. Nothing has happened in the intervening two years that would change CHA's view of the matter.

CHA's Concern About Capital

CHA's concerns about incorporating capital costs into the DRG payments was caused by two factors:

First, CHA believed Catholic hospitals would on average do less well than other facilities under PPS national rates. This belief has been corroborated by several CHA research efforts as well as by studies conducted by the Congressional Research Office (CBO);

Second, many Catholic hospitals, especially those associated with multi-hospital systems are at the beginning of their capital cycles, i.e., they recently undertook large capital financings for renovations and other purposes.

Accordingly, CHA's serious reservations concerning the impact of any Medicare capital proposal on its membership, has caused it to be very hesitant about endorsing such proposals.

More recently, CHA's reservations about capital have been deepened by the wholly inadequate rates of increase in PPS operating payments hospitals have experienced during the past two years. The even more serious prospect that the Gramm/Rudman/Hollings deficit reduction act will cause those rates to remain substantially below hospital input prices in each of the next five years, confirms our doubts that the government cannot presently deal with the capital issue as anything other than one more mechanism for further reducing the federal deficit.

Mr. Chairman, CHA understands the threat that federal deficits of unprecedented magnitude pose to the nation's economy. Furthermore, we believe all sectors of society should be required to do their fair share to bring those deficits down. Nevertheless, CHA would be remiss if it failed to mention that hospitals have been doing their share and more since the 1981 adoption of the Omnibus Budget and Reconciliation Act (OBRA).

Since then, the government has cut the Medicare program by billions of dollars; and hospitals have experienced the largest proportion of those cuts. As a result, since the early part of the decade, Medicare payments to hospitals have not kept pace with the cost of treating Medicare patients.

This experience will quickly become intolerable should Gramm/Rudman/Hollings cause zero rates of increase in PPS payments in each of the remaining years of this decade. Should this occur, the enclosed chart demonstrates that the federal government would force the nation's hospitals to absorb 100 percent of the almost 40 percent projected increase in hospital input prices between FY 1985 and FY 1991.

Even if the government allowed hospitals a 2 percent annual increase in Medicare payments in each of the next five years, PPS payments would still fall almost 60 percent short of the total projected increase in hospital input prices. Still too much of a budgetary hit; especially when, theoretically, half of the nation's hospitals have been making massive reductions in their operating costs in order to get under projected national PPS payments.

If the government incorporates capital into the prospective payment system based on average capital cost per discharge, capital payments per discharge will be 17 percent to 40 percent below average hospital capital costs by the 1991 end of Gramm/Rudman/Hollings. This effect clearly exacerbates, beyond the point of acceptability, the adverse impact a capital payment mechanism based on average capital dollars per discharge is likely to have on large numbers of highly leveraged hospitals that are at the beginning of their capital cycles.

PROJECTED HOSPITAL INPUT PRICES (1985-1995) VS VARIOUS RATES OF INCREASE IN PPS PAYMENTS

	Hospital Market Basket [1]	PPS Rate	indexed by 1.0 til 1992 [2]		indexed by 1.02 til 1992 [3]	
FY 85		3000*		3000		3000
86	1.056	3168	.0	3000	.0	3000
87	1.061	3361	.0	3000	1.02	3060
88	1.060	3563	.0	3000	1.02	3121
89	1.057	3766	.0	3000	1.02	3184
90	1.054	3969	.0	3000	1.02	3247
91	1.054	4183	.0	3000	1.02	3312
92	1.054	4409	1.054	3162	1.054	3491
93	1.054	4647	1.054	3333	1.054	3679
94	1.054	4898	1.054	3513	1.054	3878
95	1.054	5163	1.054	3702	1.054	4087

*For the sake of example, PPS rates in FY 85 were assumed to be $3000.

[1] Between FY 85 and the end of FY 91 the time at which the budget is expected to be in balance, the hospital market basket will have increased by 39.46%.

FY 86 FY 91
1.056 x 1.061 x 1.06 x 1.057 x 1.054 x 1.054 = 1.3946

[2] If Gramm/Rudman/Hollings means zero rate of increase in PPS rates until FY 1992 that means hospitals will have to absorb a 39.46% increase in their input prices. (This includes a zero rate of increase in rates between FY 85 and FY 86.)

[3] If under Gramm/Rudman/Hollings PPS rates increased by 2% a year PPS rates would increase by 12.6%

FY 86 FY 87 FY 88 FY 89 FY 90 FY 91
1.0 x 1.02 x 1.02 x 1.02 x 1.02 x 1.02 = 1.126

This would mean that between FY 85 and the end of FY 91 hospitals would have to absorb a 23.85% of the 39.46% increase in input prices (1.2946 ÷ 1.126 = 1.2385) or 60.4% of the increase in input prices.

[4] If under Gramm/Rudman/Hollings hospitals were granted an annual increase in PPS rates on the order of 3% that would mean that between FY 85 and the end of FY 91 PPS rates would increase by 19.4%

FY 85 FY 86 FY 87 FY 88 FY 89 FY 90 FY 91
1.0 x 1.03 x 1.03 x 1.03 x 1.03 x 1.03 x 1.03 = 1.194

Under this scenario hospitals would be expected to absorb 16.8% of the 39.46% increase in input prices or 42.57% of the increase in input prices.

Other Matters of General Concern

Mr. Chairman, before I address myself to the relative merits of several of the proposed capital methodologies, I would like to share CHA's deep concerns about two other aspects of the environment in which the Medicare capital proposal issue is being discussed.

First, there is not enough detail about any of the proposals to permit a precise analysis of what their effect would be on individual hospitals. For instance, details on the Administration's capital proposal have been especially sparse. The proposal is outlined in the President's FY 1987 budget, but the budget description focuses more on what the proposal is projected to save the government than on how it would work.

While bits of additional information about the proposal were revealed during the Administration's recent appearance before the House Ways & Means health subcommittee, too many important elements remain unavailable. The most important of which is the proposed separate dollar amounts for the urban and rural payments and the calculations as to how the Department of Health & Human Services arrived at those amounts. The Department had to know these amounts in order to determine its capital proposal's projected budget savings; unless, of course, those savings were projected on the basis of gross estimates. In any event, the Department has the capacity to calculate the dollar amount it is planning to publish on June 1, 1986, and should reveal them immediately so that hospitals and the Congress can determine their reasonableness.

Another critical missing detail is the annual amount by which the Administration plans to roll the total PPS payments forward. In the absence of these and other critical details it would be impractical for any hospital or hospital association to endorse or support a capital proposal.

Even with respect to your own capital proposal*, Mr. Chairman, a precise analysis of its potential effects on hospitals has been handicapped by the fact that the Senate does not have access to the Health Care Financing Administration's (HCFA) data base. Such information is necessary in order to make reasonable judgements about such important matters as what the capital dollar amount should be.

While there are aspects of your proposal that cause CHA clearly to prefer it to the Administration's (most notably the transition mechanism), the absence of a dollar value for the capital amount makes it difficult to evaluate and impossible to embrace. (Later in our testimony, CHA will make some assumptions about dollar values and other matters and evaluate the impact of capital proposals based on those assumptions.)

Another issue of general concern to CHA is the patent abuse the Office of Management and Budget (OMB) has made of the discretion Congress left to the Secretary under the PPS statute. Repeatedly since the FY 1983 implementation of PPS, OMB has forced HHS to implement prospective payment system policies that were more extreme than the best professional and programatic judgement within Congress and at HHS deemed desirable.

There is every reason to believe that OMB will continue to abuse the Secretary's statutory discretion under PPS--unless it is specifically prevented from doing so by statute. Accordingly, CHA strongly believes that Congress must specify in the proposed statutory language such matters as the dollar value of the capital add-on, the factor for updating the add-on, etc. Unless such details appear in the statute, CHA will have little or no confidence that Congressional intent regarding the equity and reasonableness of a capital proposal will be respected by OMB.

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* The Fair Deal Capital Payment Act of 1986 (S. 2121)

Evaluation of Capital Proposal

Mr. Chairman, CHA has developed a rather elaborate and detailed methodology that allows an individual hospital to evaluate the potential effects on the facility of any of a variety of Medicare capital proposals. This methodology is also arrayed on an electronic spreadsheet. The electronic spreadsheet allows a hospital to test quickly and easily changes in the variables of various capital proposals. For instance, what happens to the hospital's Medicare payment when the transition is lengthened or shortened, when the dollar amount is increased or decreased, etc.

CHA has sent the methodology to all Catholic hospitals and multi-hospital systems. We already have some early returns.

At this time, I would like to share with you the relative impact of your proposal and the Administration's on one of CHA's member facilities.

The hospital is a large teaching facility in a midwestern city. It is also at the very beginning of its capital cycle.

The hospital just went through a major renovation/replacement of parts of its plant that were originally built more than fifty years ago.

We have selected this hospital as a case study, Mr. Chairman, because it is widely regarded within the hospital community as a facility that is operated efficiently and has made consistently sound business decisions with respect to its capital acquisitions and financings.

The hospital began planning for the replacement in 1979 and received the necessary state and local approvals in 1981. The project financing was obtained almost two years prior to the April 1983 adoption of the Medicare prospective payment system.

In the process of using the CHA methodology to evaluate the possible effects of the Administration's capital proposal the hospital made the following assumptions:

- o The national urban PPS capital amount would be $258.79 for FY 1987. (The number was derived by the California Hospital Association based on assumptions supplied to it by the Catholic Health Association.)
- o Relative to the annual PPS payment update the hospital evaluated the Administration's capital proposal under each of the following assumptions:
    - PPS rates updated on an annual basis in accordance with projections issued by the Trustees of the Hospital Insurance Trust Fund.
    - under Gramm/Rudman/Hollings PPS rates were updated by 2% each year until 1991 and thereafter by the hospital market basket as projected by the Trustees of the Hospital Insurance Trust Fund.
    - under Gramm/Rudman/Hollings PPS rates were updated on an annual basis by 0% until 1991 and thereafter by the hospital market basket as projected by the Trustees of the Hospital Insurance Trust Fund.
- o The hospital specific portion for both the Administration's proposal and your proposal, Mr. Chairman, is based on the hospital's actual capital costs

for the year in question. (Therefore, the hospital's assessment of the Administration's proposal somewhat understates its adverse impact.)

The following chart demonstrates the impact of the two proposals vis a vis the hospital's current and already obligated capital costs under 3 different PPS rate update scenarios in the fifth years of the capital fold-in, i.e., FY 1991.

Impact of Medicare Capital Proposal on Current and Obligated Capital Costs in FY 1991

$ Add-On Assumed to be $258.79

		Market Basket		G-R-H 2% increase in PPS rates		G-R-H zero % increase in PPS rates
PRINCIPAL INTEREST						
5 Yr	(1995)	-$114,153	(1998)	-$336,126	(2000)	-$449,057
(even)	(1999)	-$541,307	(2004)	$943,483	(2007)	-$1,147,966
7 Yr		+$928,068		+$830,955		+$781,547
(front-loaded)		+$2,717,592		+$2,565,506		+$2,488,148
DEPRECIATION INTEREST						
5 Yr	(2000)	-$1,852,837 (-41%)	(2002)	-$2,074,810 (-45%)	(2003)	-$2,187,741 (-48%)
	(2008)	-$4,792,535 (-27%)	(2010)	-$5,374,711 (-29%)	(2011)	-$5,579,194 (-30%)
7 Yr	(2000)	-$810,616 (-18%)	(2002)	-$907,729 (-20%)	(2003)	-$957,134 (-21%)
		-$1,713,636 (-9.2)	(2009)	-$1,865,722 (-10%)	(2010)	-$1,943,080 (-10.5%)

(2000)[3] -$1,852,837[1] (-41%)[2]

(2008)[6] -$4,792,535[4] (-27%)[5]

[1] annual gain or loss in $

[2] annual gain or loss as a % of cost

[3] break even point where payment covers cost

[4] accumulative gain or loss in $

[5] accumulated gain or loss as a % of cost

[6] recoupment point when hospital recovers earlier losses

The chart demonstrates that under the Administration's proposed 5 year even phase-in the hospital would not receive sufficient reimbursement to cover its principal and interest payments until 1995 under the market basket scenario; and not until the year 2000 under Gramm/Rudman/Hollings assuming a zero rate of increase. The variance or short-fall from the hospital's current and obligated capital costs would be 41% under the optimistic market basket scenario, and 48% under the Gramm/Rudman/Hollings zero rate of increase scenario. The hospital's break-even or crossover point isn't reached until the year 2000 under the optimistic scenario and not until 2003 under the Gramm/Rudman/Hollings scenario. Thus, the Administration's proposal would threaten the hospital's viability even under the optimistic assumption that the total PPS payment would be rolled forward by the hospital market basket.

The chart also demonstrates the 7 year front-loaded phase-in contained in your proposal, Mr. Chairman, would make it possible for the hospital to meet its debt service obligations with respect to current and obligated capital. However, even with the longer front-loaded phase-in, the short-fall from the hospital's capital costs as measured by depreciation and interest is still sufficiently severe and prolonged that the hospital would have insufficient funds to make the necessary equity contributions when the time comes to renovate and replace major fixed equipment in the late 1990s and early 2000s.

The following chart compares the hospital's total Medicare PPS revenue to be received to its total expected Medicare costs for services covered by PPS under both your proposal, Mr. Chairman, and the Administration's. This includes current and obligated capital costs, future capital costs and operating costs.

Summary Comparison of Total Medicare PPS Revenues to Total Medicare PPS Costs FY 1991

$ Add-On Assumed to be $258.79

		Market Basket	G-R-H 2% increase in PPS rates	G-R-H zero % increase in PPS rates
5 Yr	(2007)	-$2.2M (-5.3%)	-$7.7M (-18.5%)	-$10.4M (-25%)
	(never)	-$5.5M (-3%)	-$20M (-12.9%)	-$27.0M (-17.5%)
7 Yr	(2005)	-$1.2M (-2.9%)	-$6.6M (-15.9%)	-$9.2M (-22%)
	(never)	-$2.2M (-1.4%)	-$16.6M (-10.7%)	-$23.4M (-15.2%)

(2007)[3] -$2.2M[1] (-5.3%)[2]

(never)[6] -$5.5M[4] (-3%)[5]

[1] annual gain or loss in $

[2] annual gain or loss as a % of cost

[3] break even point where payment covers cost

[4] accumulative gain or loss in $

[5] accumulated gain or loss as a % of cost

[6] recoupment point when hospital recovers earlier losses

The first and most obvious point the chart makes is that the losses experienced by the hospital on the capital side are cannot made up on its operating side.

The second point, is that the hospital cannot sustain a zero rate of increase under Gramm/Rudman/Hollings.

It is not clear from this chart whether the hospital can sustain itself under a Gramm/Rudman/Hollings scenario in which PPS rates are updated by 2% each year until 1991 and then by the hospital market basket each year thereafter. The hospital will, however, experience future capital costs associated with replacement of wornout fixed equipment in the late 1990s and early 2000s. The addition of these costs make the shortfalls the hospital will experience deeper and more prolonged even under a 7 year front-loaded phase-in. The impact of these anticipated short-falls is so severe that even with a 2% increase in the PPS rates under Gramm/Rudman/Hollings followed by market basket increases in PPS rates in 1992 and thereafter, your proposal, Mr. Chairman, would generate a level of funds insufficient to meet the hospital's minimum capital requirements.

From the data presented, one can safely conclude that the Administration's capital proposal is clearly unacceptable under any of the scenarios relative to inflation in the PPS rates. One can also safely conclude that a zero rate of increase in PPS rates under Gramm/Rudman/Hollings is also unacceptable. We can also safely conclude that the fact that a hospital entered into its capital obligations well prior to April 1983 is no guarantee that it will be able to cope with a Medicare capital payment mechanism; even one with a front-loaded transition mechanism.

Summary and Conclusion

In summary Mr. Chairman, at this time, CHA believes that:

1. In order to proceed responsibly with the debate over incorporating capital costs into the PPS rates both Congress and the hospital sector need to be discussing the value of any add-on in actual dollars and cents terms.

   In the absence of such a number, or numbers, hospitals cannot reasonably evaluate the actual impact on them of various capital proposals. Furthermore, unless such a number, or numbers is written into the statute hospitals cannot be confident that the capital agreement arrived at between the Congress and the hospital sector would survive the Office of Management and Budget's regulatory process.

2. Identifying a capital payment mechanism that is fair and equitable will be more difficult than all of us originally anticipated, and the impact of Gramm/Rudman/Hollings will add substantially to that difficulty.

   The hospital cited in our testimony is but one example of a large number of Catholic and other hospitals in similar situations that are in danger of going under financially if the capital proposal that is finally implemented isn't carefully thought out and examined before-hand.

3. Congress should act at its earliest opportunity to preclude the Administration from proceeding to implement its capital proposal by regulation.

Thank you Mr. Chairman, for the opportunity to appear before you and the Committee today. This concludes my prepared remarks. I would be happy to answer any questions.

Senator Durenberger. Mr. Gage.

STATEMENT OF LARRY S. GAGE, PRESIDENT, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS, WASHINGTON, DC

Mr. Gage. Thank you very much, Mr. Chairman. I will also submit my statement for the record and just summarize a few points that I think are important to add to what has been said up here.

First, I do want to thank you for your support for public hospitals and disproportionate share hospitals in the context of the reconciliation act. I think that support which began nearly 5 years ago in the context of the Medicaid program, underscores the attention we think needs to be paid to certain categories of hospitals, whether it is in the defining of a capital reimbursement program under Medicare, or in a variety of other issues that you are looking at this year in the tax bill and elsewhere.

I want to come back to what Senator Baucus said a short time ago, because I think it is important to recognize that the combination of trends—the move toward prospectivity in the Medicare and Medicaid programs, the competitive pressures well underway in most parts of the country in the private sector, the trends in medical practice away from inpatient care and towards outpatient care—all of these trends are established facts. And one of the primary results of these trends is going to be an overall reduction in inpatient hospital capacity in many parts of this country. There is no question that this is a goal of many aspects of our health system, to reduce both the number of hospitals and the number of beds. And the question is: Are competitive pressures alone, or is efficiency driven prospective fixed pricing alone, going to make the decisions as to which hospitals and which beds are eliminated from the system?

We believe the answer cannot be that competitive and payment trends alone are going to be making those decisions. We think Congress has recognized this in trying to carve out some special attention to the needs of classes of hospitals like sole-community hospitals and urban area public hospitals in fashioning the Medicare prospective payment system. And we just want to underscore that this has to be done in the capital reimbursement and financing area as well.

Public hospitals in urban areas face something of a paradox in the Medicare capital arena. We are, as Gerry Anderson and others have pointed out over the last couple of years, the most under-reimbursed segment of the industry for capital financing under the current system. A major urban public hospital, on average, gets about 3.9 percent of its Medicare revenues as capital payment, as compared to the 7 percent national average.

The fact is, if you folded capital into DRG's tomorrow, in some kind of 7 percent solution, with no phase in at all, many of my members and clients would be substantial beneficiaries of that. However, there are reasons for the low rate of reimbursement that have to do with the nature of the physical plants of these hospitals. Our member hospitals, on average, have physical plants that are 12½ years old. Compare that to Council of Teaching Hospital members generally, which have an average of 7.4 years, or non-COTH hospitals, with an average of 6.7 years. You will see that there is a substantial unrecognized need for future capital. We have polled our own members, and just 20 of our members identified about $900 million in very specific capital needs over the next few years.

By contrast, some of the public hospitals that have been able to continue to get access to capital—and I give some examples in the testimony—are in the situation that Mike and others have alluded to earlier. They have undertaken recent capital financing projects that need to be taken into account. But the majority of our members have future needs that, if they are going to continue to provide the services that they are providing to their communities, they are going to need to find some way to meet.

We do have a capital policy agenda for public hospitals. It is spelled out in some detail in our testimony. It is not limited to Medicare reimbursement. We include, for example, several observations on the House-passed tax bill. We have several observations about credit enhancement programs, in that we think we are going to need some special programs to enable public hospitals to gain access to capital.

Finally, as with the other witnesses on this panel, and, despite the fact that public hospitals in general would probably gain from a rapid implementation of a "7 percent solution" in the very short run, we think you need to have a much more sensitive approach than the administration's proposal, one that phases in through legislative action a very carefully designed Medicare policy. And we strongly agree with Senator Baucus that you must have some kind of sensible outlier policy that takes into account, among other aspects of our health system, the particular needs of metropolitan area public hospitals.

Senator DURENBERGER. Very good. [Laughter.]

Well timed.

[The prepared written statement of Mr. Gage follows:]

STATEMENT OF LARRY S. GAGE
President and General Counsel
National Association of Public Hospitals

March 14, 1986

Before the Subcommittee on Health
Committee on Finance
United States Senate

Mr. Chairman, members of the Subcommittee, I am Larry Gage, President and General Counsel of the National Association of Public Hospitals. NAPH consists of 60 public hospitals and hospital systems that serve as major referral centers and hospitals of last resort for the poor in most of our Nation's largest metropolitan areas.

I am particularly pleased to have this opportunity to testify before the Senate Finance Committee again today, because the NAPH greatly appreciates the attention the Committee has paid in recent years to the many difficult and important health care issues confronting "disproportionate share hospitals." We are especially grateful for your attention to the needs of such hospitals in the context of current efforts to reduce Medicare payment levels to hospitals generally, and major teaching hospitals in particular, in the pending Budget Reconciliation Act Conference Report.

We welcome the opportunity this morning to provide you with our observations regarding two current proposals concerning how capital costs should be paid for under the Medicare program. First, we will respond to the Administration's proposal that capital payment amounts be incorporated by regulation into the non-labor portion of Medicare prospective payments during a four-year transition period. Second, we will respond to the proposed Fair Deal Capital Payment Act of 1986, recently announced by Senator Durenberger, which would also incorporate capital costs into PPS payments, but with a seven-year phase-in period and by statutory amendment, rather than by agency regulation.

We will discuss these two proposals in a broader context, however, because we believe it is important for the committee to understand and appreciate the extremely precarious capital situation of many NAPH members and other essential providers of care to the poor.

For example, a superficial analysis might indicate that large, metropolitan area public hospitals as a group receive the lowest average capital pass-through of any category of hospitals in the nation -- less than 4%, as compared with about 7% nationwide. However, a closer look will reveal that this is due in large part to the older, more deteriorated physical plants of such hospitals. Hospitals in that condition might therefore realize a "windfall" in the short run from rapid implementation of a 7% capital add-on to Medicare/PPS payments. In the long run, however, such hospitals would more likely experience greater deterioration in their ability to make future capital expenditures necessary to enable them to continue filing their unique and valuable "safety net" role. I believe we all agree that this role is a necessary and appropriate one, particularly at a time when increased competition throughout the nation's health system continues to increase pressure on hospitals serving low income patients. For this reason, our basic position on Medicare capital payments is this: whatever action you may take regarding such payments for the hospital industry generally, we believe you must provide some measure of additional flexibility, perhaps on a case by case basis, to address the special needs of such hospitals.

Finally, we believe it is important for the Committee also to appreciate that other Congressional and regulatory actions this year can also have an impact on the ability of urban public hospitals to gain access to capital. These include tax reform and the increasing need for additional credit enhancements, such as under the FHA hospital mortgage insurance program.

Although Medicare payments of capital play a significant role in the capital financing situation for hospitals, Medicare's treatment of such costs is only one part of a much larger picture. A signal feature of this picture over and above the issue of reimbursement, is access to capital, whether such access it is obtained through tax-exempt financing, or through credit enhancement programs, such as the Hill-Burton program or FHA mortgage insurance under S242 of the National Housing Act. Since several of these issues are also within the jurisdiction of your Committee, and tax exempt financing in particular is presently under active consideration, we would like to provide you with our observations on these issues as well, as part of our overview of the capital situation of NAPH members today.

For these reasons, the remainder of my testimony this morning will be divided into three sections: Section I will describe the capital characteristics and capital needs of NAPH members and other public hospitals generally, including a comparative analysis of the current Medicare capital reimbursement received by such hospitals. Section II will provide several specific examples of the capital situation of particular NAPH member hospitals. Finally, Section III will provide our specific comments on Medicare capital reimbursement, and other capital-related issues affecting public hospitals today.

I. Capital Characteristics and Capital Needs of Public Hospitals

It is generally acknowledged that the hallmarks of public hospitals -- serving a high number of indigent patients, relying on major support from public sources of revenue, operating older and, at times, obsolete physical plants, and failing to have an overall competitive "attractiveness" to patients and private payers -- are also formidible obstacles in obtaining access to capital. The investment community has historically eschewed institutions with such profiles, absent governmental guarantees or other credit enhancements. However, traditional public sources of capital financing (e.g., general obligation bonds, state or local appropriations) have become far more unreliable due to the relatively greater fiscal weakness of many localities, increased demands for taxpayer and community dollars, and in some cases, outright taxpayer revolt. And all the while, many urban public hospitals see a greater proportion of low income patients, face increasing deficits and grow older and older.

What is the current financial situation of public hospitals with regard to capital? What role have Federal programs played in supporting capital initiatives? What sources have public hospitals used to support capital? What are the capital needs of these facilities and what does the future portend for financing of their capital improvements? The following sections identify the capital situation of urban public hospitals and consider their capital requirements for the remainder of this century. The information presented here is based upon a small but reliable sample of large urban public hospitals, re-verified through 1984, the latest date for which information is available.

A. Capital Financial Characteristics of NAPH Members

TABLE I presents financial ratios and other selected financial characteristics affecting hospitals' ability to obtain access to sources of capital. Comparisons of critical indicators of capital "attractiveness" confirm the assertion that public hospitals are in a uniquely precarious position and are at a severe disadvantage when competing for funds in the capital marketplace.

1. Age of plant. The average age of an NAPH member's physical plant is 12.5 years (TABLE I). This average is well above the Council of Teaching Hospitals (COTH) average of 7.4 years - a group that also includes the majority of NAPH members - as well as the non-COTH average of 6.7 years. In fact, when NAPH is compared to COTH and non-COTH hospitals by census region, the NAPH member's average plant age exceeds every area and every hospital average in the country (TABLE II). This substantial age difference reinforces the belief that many of the large urban public institutions are in a singularly serious situation with regard to their capital needs.

2. Ratios of current assets to liabilities. The ratio of current assets to liabilities (i.e. the current ratio) is often used as one of a number of indicators of hospital attractiveness in the bond market. For example, Standard & Poors has determined that a hospital with less than average current assets to liabilities have ratios below 2.0. NAPH members average 1.9, indicating relative non-liquidity of funds, and symptomatic of the financial stress they suffer.

3. Maximum debt service coverage. TABLE I identifies NAPH members' maximum debt service coverage, which represents current capacity to carry their debt. Six of the 10 members responding identified a ratio of 2.0 or less.

According to investment analysts, hospitals whose maximum debt service coverage is roughly 2.0 or less would fall into a A- or lower bond rating. These hospitals would have "no real market" for obtaining capital, and would need mortgage insurance or some other assurance to support their profile. Thus, 6 of the 10 responding NAPH members would require such support.

4. Ratio of debt service to gross patient revenues. NAPH members' debt service to gross patient revenue ratio averages 2.9%, indicating that there is not much debt outstanding. In theory, it could mean that they could take on capital projects. However, these facilities, in general, are often very old due to their previous inability to obtain capital support. That is,

public hospitals often cannot find sources willing to finance debt for capital. The result is an old plant that cannot be renovated.

TABLE I

Selected Financial Characteristics of NAPH Members - 1983

Average Age of Plant	12.5 years (20 hospitals)
Ratio of Current Assets to Liabilities	1.9 (average) (22 hospitals)
Ratio of Debt Service to Gross Patient Revenues (expressed as a percent of gross patient revenue)	2.9% (average) (15 hospitals)
Maximum Debt Service Coverage	Average: 2.6 range: -2.1 to 8.7 (10 hospitals)

TABLE II

Average Plant Age (in years) in Short Stay Non-Federal Hospitals by Membership in COTH and Census Region, 1982

	Average Age of Plant*	
	COTH Hospitals	Non-COTH Hospitals
New England	8.74	8.16
Middle Atlantic	8.00	7.53
South Atlantic	7.04	6.19
East North Central	6.81	7.17
East South Central	7.32	6.22
West North Central	7.51	7.21
West South Central	6.74	6.01
Mountain	5.80	6.05
Pacific	7.74	5.99

$$\text{* Average Age of Plant} = \frac{\text{Accumulated Depreciation}}{\text{1982 Annual Depreciation}}$$

Source: AHA Annual Hospital Survey

Excerpted from: J. Bentley, "Toward an Understanding of Capital Costs in COTH Hospitals", 1984.

B. Capital Reimbursement under Medicare and Medicaid

TABLE III identifies 1983 Medicare and Medicaid depreciation reimbursement (i.e. depreciation of capital assets) and debt principal payments (i.e. payments for new investments) to NAPH members. As expected, average depreciation reimbursement to members was substantially higher for both programs than were debt principal payments. These public hospitals averaged $790,000 in Medicare depreciation reimbursement and $730,000 in Medicaid depreciation reimbursement. Debt principal payments, however, were very low, averaging $30,000 per hospital for Medicare and $40,000 for Medicaid, including 18 hospitals that reported "zero" reimbursement for debt principal payments.

NAPH members differ dramatically when these findings are compared to other sectors of the hospital industry. A 1982 report (Kinney and Lefkowitz) investigated the relationship of Medicare and Medicaid depreciation reimbursement to debt principal payments (See TABLE IV). As indicated, proprietary hospitals represented the greatest proportion of debt principal to depreciation payments, 81.8%, ($90.0 million/$110 million), followed by voluntary hospitals, 50.48% ($530 million/$1,050.0 million); public hospitals demonstrated the lowest proportion, 25% ($60.0 million/$240 million). However, NAPH members' debt principal/depreciation reimbursement, is substantially below these levels: 4.7% ($1.7 million/$36.5 million).

Recent studies confirm the extreme situation of urban public hospitals. For 1983, capital costs accounted for 7% of Medicare reimbursements to hospitals in general. Payments to public hospitals with over 400 beds averaged 3.9% overall, lower than any other category measured (Anderson & Ginsberg).

TABLE III

Medicare and Medicaid Capital Reimbursement to NAPH Members - 1983
(in millions)

	Medicare		Medicaid			
	Total	Avg.	Total	Avg.	Total	Avg.
Depreciation Reimbursement No. of hospitals 24	18.90	.79	17.62	.73	36.52	1.51
Debt Principal Payments No. of hospitals 24*	.75	.03	.96	.04	1.71	.07

* 18 hospitals reporting Medicare and Medicaid reimbursement indicate no debt principal payments accrued.

What are the implications of these findings for large city public hospitals? More than any other group, these institutions' assets are the oldest while their investment in new capital is extremely low. And while the availability of discretionary funds for proprietary and not-for-profit hospitals represents monetary support for additional capital expansion and investment, the public hospitals "discretionary" funds are most often used for other purposes, in particular to cover operating deficits resulting from providing high amounts of bad debt and charity care.

TABLE IV

Estimated Depreciation Reimbursement and Debt Principal Payment by Type of Community Hospital, FY 1981 ($ in millions)

	Voluntary	Proprietary	Public	All Community Hospitals
Total Medicare and Medicaid Reimbursement	22,700	2,470	6,080	31,250
Depreciation Reimbursement	1,050	110	240	1,400
Debt Principal Payment	530	90	60	680
Difference Between Depreciation and Debt Principal (Discretionary Funds)	520	20	180	720

Sources: AHA, Hospital Statistics, 1980 Edition and AHA, 1977 Annual Survey (Unpublished Data).

Excerpted from: E. Kinney & B. Lefkowitz, "Capital Costs to Community Hospitals under the Federal Health Insurance Programs." *Journal of Health Politics, Policy and Law*, 1982.

C. Funding For Capital Initiatives

NAPH members, like other sectors of the hospital industry, have relied primarily on debt to finance capital construction and renovation. Long-term debt accounted for for more than half of the more than $200 million obtained by these public hospitals. NAPH members also relied on local governments and internal funds for supporting almost $100 million in capital projects. Philanthropy and Federal government sources by far contributed the least to member capital funding.

D. Debt Financing of Capital

Don Cahodes has reported a substantial increase in financing of capital through tax-exempt public offerings from 1973 (36.2%) of financing) to 1979 (80.6%). Private placements, conventional mortgages, government sponsored programs and taxable public offerings have all deceased dramaticallly during that period.

For NAPH members, although debt financing information is incomplete, the importance of tax exempt public offerings, as identified by Cahodes, is evident. For the three years examined, NAPH members identified a total of more than $200 million in tax exempt public offerings - more than three-quarters of all debt financing reported (private placements were a distant second). And in 1983 this mechanism represented almost 90% of debt financing. Of critical importance during these years, however, is the decrease in taxable public offerings and the virtual absence of support from almost all other sources. For example, in 1983 none of the reporting hospitals identified financing through taxable public offerings, while two hospitals had obtained financing through conventional mortgage loans or Federal government programs for a total of only $600,000. Thus, members' access to debt financing, in general, has been confined to what the tax-exempt mechanism, and, to a lesser extent, private placements, have allowed.

E. Capital Needs of NAPH Member Hospitals

NAPH members who responded to the request for information on capital needs identified in the aggregate at least $900 million (TABLE V) over the near term. Almost 84% of these needs were related to basic building construction and renovation, including the following: a trauma center, a surgery building, all or a major part of a hospital (5 hospitals) an ancillary services facility; a children's clinic; and pediatric and neonatal intensive care units. The estimated building needs approach $40 million per member.

Equipment need estimates approach $140 million for 21 hospitals, and include radiology and laboratory equipment, CT and NMR equipment, operating room tables, anesthesiology systems. Comparatively little funding is forseen for land (total $6.3 million).

Although the $900 million total recognizes that substantial capital need exists at NAPH institutions, it is essential to recognize that these estimates underrepresent significantly the total capital needs of NAPH members since many hospitals list only capital projects that are likely to be funded over the next few years. Public hospitals demonstrated the lowest rate of increase in capital expenditures (5% for a five year period from the mid to late 1970s), when compared to voluntary facilities (15.6%) and proprietary institutions (12.1%) (Kinney & Lefkowitz), 1982). Moreover, some NAPH members who require a total or major renovation/reconstruction of their physical plants did not list or estimate the projects on their "wish lists" since funding will not occur.

TABLE V

Estimated Capital Needs of NAPH Members through 1988 (in millions)

	Total	Average
Building No. of hospitals: 19	$731.1	38.5
Moveable Equipment No. of hospitals: 21	$136.1	6.5
Land No. of hospitals: 4	$ 6.3	1.6
Total	$873.5	

II. EXAMPLES OF THE CAPITAL SITUATION OF SPECIFIC NAPH MEMBER HOSPITALS

Unlike so many other hospitals, essential providers of care to the poor, such as NAPH members, typically do not require capital financing merely to install major medical equipment which represents the latest trend in technology, nor to embark on the cosmetic changes needed to create a competitive, "upscale" facility. These hospitals are, instead, attempting to address severe structural deficiencies, often which threaten the hospital's very accredition and patient safety. Furthermore, these projects typically do not expand bed capacity. Instead they carry out the best health planning objectives: downsizing inpatient capacity in favor of more cost-effective ambulatory care; sharing technology and resources among facilities; and other innovations to provide more efficient care within a limited operating budget.

A. California County Hospitals - 1984 Survey Data

Recently, NAPH surveyed member county hospitals in California to obtain a more concrete picture of their capital needs. This survey found that 6 county hospitals needed complete replacement at a total cost of $742.7 million (one hospital required complete replacement at a cost of $370.0 million).

These replacements were required for several reasons, including:

- old and outdated facilities were not cost-effective to maintain; and
- numerous deficiencies were cited by license and accreditation agencies as well as grand jury citations, agencies rendering the hospital noncompetitive.

Examples of those deficiencies include: surgical suite with inadequate ventilation; old flooring that had become an infection hazard; improving emergency back-up systems.

Of the estimated $262.0 million needed for partial renovation, expansion and equipment, about $65.0 million were related to JCAH, grand jury or state citations (e.g. installing air conditioning on impatient units, adding bathrooms, increasing electrical capacity).

Over $120 million were identified as necessary to meet increased service requirements and service system efficiencies (e.g. responding to increased demand for OB/GYN and neonatal services; expanding patient waiting areas; removing asbestos; replacing or expanding sewer lines).

Outpatient capital improvements totalled $122.7 million, including $29.8 million for total out patient replacement.

B. Other NAPH Member Hospitals

1. PARKLAND MEMORIAL HOSPITAL

Parkland Memorial Hospital is the major public hospital in Dallas, Texas. During 1983, this 821-bed facility maintained an occupancy rate of 82% and admitted almost 36,000 patients. Parkland also provided 267,000 outpatient visits and 167,000 emergency room visits. In 1983, Medicare represented 12.5% of $246.6 million in gross revenues at the hospital. Private insurance and Medicaid accounted for, respectively, 13.3% and 5.5% of these revenues, and city and county appropriations covered most of the remaining 68.7%.

Parkland's 1985 Medicare capital payment of $2.1 million equalled 13.0% of total actual Medicare reimbursement. Capital renovations exceeding $80.0 million are currently underway, involving a large part of the hospital as well as a replacement of equipment. Still, projected five-year capital needs for equipment, parking and other programs exceed $65 million.

2. COOK COUNTY HOSPITAL

Cook County Hospital is a public institution with over 1200 beds in Chicago. With a 68% occupancy rate, it accounted for almost 41,000 inpatient admissions in 1983. During that year, Cook County provided 375,000 outpatient visits and an additional 289,000 emergency room visits. Medicare represented 10% of the

$212.2 million in revenues, with an additional 34% covered by Medicaid and private insurance. City and county appropriations accounted for over 50% of the revenues for the hospital. Cook County's Medicare capital payments during 1985, $.44 million, equalled only 1.8% of total Medicare reimbursement for that year. However, the capital needs at the institution are substantial. A replacement hospital may be needed in the near future, and while such a hospital would undoubtedly be smaller in scope than the present facility, the costs would still be substantial. Even without a replacement hospital, Cook County will require at least $33 million to renovate the existing 1913 facility's various services, including adult and pediatric emergency rooms, cardiac laboratory, and trauma unit improvement.

3. GRADY MEMORIAL HOSPITAL

Grady Memorial Hospial is the major public hospital in Atlanta, Georgia. With 1012 beds and 78.5% occupancy rate in 1983, Grady had over 45,000 admissions, 482,000 outpatient visits and 258,000 emergency room visits. Medicare accounted for 21% of the $112.6 million in 1983 revenues. Medicaid and private insurance represented, respectively, 22.4% and 11.1% of the revenues for that year.

During 1984 Grady received $1.15 million in Medicare capital payments, or 3.6% of the $32 million in total Medicare Reimbursement. While renovations during the previous five years have been relatively minor (e.g., $2.5 million for radiology, $1.5 million for laboratory equipment and facilities), the hospital estimates that $125 million will be required in the next few years for major renovations (e.g., reducing eight-and four-bed wards, building stairwells required by JCAH, installing bathrooms and adding needed clinics).

4. BOSTON CITY HOSPITAL

Boston City Hospital (BCH) is the major urban public hospital serving residents of the city. During 1983, with 541 beds and an occupancy rate of 79%, discharges totalled 16,593. BCH also provided 139,415 outpatient visits and 73,232 emergency room visits in 1983. Medicaid was the primary payer, representing almost 50% of the $83.7 million in revenue for that year. The remaining revenue sources included private insurance (25%), Medicare (15%), city subsidy (4%) and other programs (6%).

For 1984 Medicare capital payments equalled 6.3% of the total $25.4 million in Medicare reimbursement. While only $19.5 million in capital expenditures occurred over the past five years, a substantial portion was related to life safety code violations (e.g., sprinkler system, fire doors). BCH estimates, due to serious infrastructure problems, that $175 million for a major rebuilding program needs to be expended, starting in two years.

5. WISHARD MEMORIAL HOSPITAL

Wishard Memorial Hospital is the major public hospital in Indianapolis, Indiana. During 1983, this 557-bed facility had a 63% occupancy rate and admitted 17,600 patients. It also provided almost 276,000 outpatient visits and 75,000 emergency room visits. State and local government is the major source of the $137.6 million in hospital revenues followed by Medicare (19%). Revenue from Medicaid and private insurance were 14% and 12% respectively, with nonspecified revenue making up the difference.

Wishard's 1984 Medicare capital payment of $1.2 million was nearly 5% of total Medicare reimbursement. Capital renovations during the past five years totalled $11.5 million and included laboratory renovations and establishing an ambulatory surgery center. Wishard has projected estimated capital expenditures of $10.7 million for additional renovations and equipment in the immediate future.

III. Discussion of Legislative Proposals

To summarize our position on current Medicare capital payment proposals, NAPH strongly opposes the Administration's effort to adopt regulations to phase capital payments into PPS payments quickly, over just four years, with the expectation of significantly reducing those payments by upwards of $4.2 billion in the next three years. We are particularly concerned that such an approach is a recipe, not for a "reform" of capital cost reimbursement, but for its outright demise in what has become an annual budget-driven debate over Medicare hospital payment increases. In testimony before the House Ways and Means Committee on February 24, DHHS spokesman Robert Helms suggested that this proposal promotes "flexibility," "predictability" and "efficiency." However, we would note that "predictability" is no help if the payment levels are inadequate. Also, as noted above, public hospitals have typically had no choice but to be efficient users of new capital, generally reducing the size of their physical plant, often postposing needed repairs if their publicly funded budget is tight, generally reducing the size of their physical plants when conducting major renovations, and purchasing only minimally necessary new equipment or technology. Additional "incentives" like reduced reimbursement are hardly likely to generate greater "efficiencies" than the current budget process and capital constraints already faced by such hospitals.

With regard to Senator Durenberger's proposal, we believe it represents a far more pragmatic and equitable approach to Medicare capital reimbursement, at least within the parameters of the debate over this issue today. However, we would strongly recommend that additional attention be paid to the special needs of major metropolitan area public hospitals, and particularly those which have recently undertaken, or must in the near future plan for, major capital renovations that will be necessary to enable such hospitals to continue to perform their role as essential providers of care to low income patients. We agree that such special attention can and should be tied to increased scrutiny of the necessity for capital spending, and the scope and efficiency of the projects themselves. As governmental entities, in short, we ask you to remain in partnership with us wherever necessary to ensure the continued availability of needed governmental health services. Quite simply, competition alone will not meet these future needs -- increased competition for paying patients will continue to erode the ability or willingness of many providers to serve low income patients.

B. Access To Capital Markets by Essential Providers

This final section of my testimony will summarize NAPH's comments on other issues likely to affect public hospital's future ability to obtain access to capital.

As noted above, in addition to Medicare reimbursement, the NAPH capital financing agenda also includes important issues regarding the continued availability of tax exempt financing, and access to capital generally. In this final section, I will briefly summarize our observation and concerns regarding these issues.

1. Tax-exempt Bond Financing

There are several areas of concern to urban public hospitals in the tax-exempt financing provisions of H.R.3838. In addition to our comments on Medicare reimbursement, we therefore also ask that you take our concerns into account as you prepare any alternative proposals. Those areas include in particular:

- definition of "governmental" hospital (and clarification of public use)
- early issuance (5% rule)
- expenditure of proceeds (3-year rule)
- restricting the trade or business use of governmental bonds

a. Definition of Governmental Hospital

Bonds which provide funds for use in operating a major metropolitan area public hospital should be treated as essential function ("governmental") bonds regardless of the corporate structure of the hospital. Like many state universities, a number of large, public hospitals, for example, are organized for certain purposes as non-profit or public benefit corporations, rather than as governmental hospitals. Examples include the

Truman Medical Center, of Kansas City, Missouri; the Pacific Medical Center, of Seattle, Washington (formerly a Federal Public Health Service Hospital); the Regional Medical Center of St. Louis (formerly St. Louis City and County Hospitals); the Regional Medical Center at Memphis (formerly Memphis City Hospital) and the New York City Health and Hospitals Corporation. Notwithstanding their corporate structure, these entities operate in every respect as public hospitals, and the locality they serve (state, city, county) generally maintains considerable control (e.g., appoints members to the hospital board, reviews its budget, and often provides a significant share of the funding for the hospital -- 35% of the total budget on average for members of NAPH).

H.R. 3838 provides that a bond will be treated as a "nonessential function" bond if more than 10% or $10 million of bond proceeds are used in the trade or business of any person other than a governmental unit. It is our understanding that an alternative draft proposal being prepared by Senator Durenberger would basically adopt current law with regard to "governmental" bonds, no more than 25 percent of the proceeds of which are used in the trade or business of a nongovernmental person or are secured by the revenues from such a trade or business. (Bonds which exceed the trade or business use allowance are treated as non-essential or "quasi-governmental", respectively, and, unless specifically exempted, are subject to Statewide volume limitations.) We would support this change in H.R. 3838, with the following caveat:

In defining a governmental unit, the Ways and Means Committee Report language accompanying H.R.3838 states in part that, "State owned and operated universities are governmental entities." H. Rept. No. 99-426, 99th Cong., 1st Sess., 519. A footnote accompanying this statement provides:

> "The Committee is aware that certain State universitites also have received determination letters regarding their tax-exempt status under Code section 501(c)(3). The Committee intends that, to the extent of a State-owned and -operated university's activities as a governmental unit, bonds for the State university will be treated as governmental bonds rather than as non-essential function bonds for activities of a section 501(c)(3) organization." Id.

It is important to clarify that the activities of a public hospital are similarly to be treated as the activities of a governmental unit even if the organization is formally structured as a Section 501(c)(3) hospital, such as a public benefit corporation. Thus, the activities of a public hospital would not be a trade or business either for purposes of determining the percentage of the proceeds of an issue which are used in a trade or business or of determing the percentage of the issue which is secured by revenues from a trade or business.

In addition, public hospitals often share physician services or other resources by contracting for such services or other resources with other public or private organizations (e.g., medical schools). We believe that the furnishing of services to a public hospital should not be treated as the trade or business of the organization furnishing the services, but rather should be treated as the provision of direct governmental hospital services.

b. Early Issuance/5% Rule

H.R. 3838 requires that five percent of the proceeds of a bond issue must be spent for the exempt purpose within 30 days of the issuance of the bonds. We are concerned that this requirement is unnecessarily burdensome on many governmental issuers and may prevent some localities from engaging in any public financing due to additional local law restrictions on public projects. NAPH strongly endorses the proposal that has been made to eliminate this restriction and retain present law.

c. Expenditure of Proceeds/3 Year Rule

In addition, H.R. 3838 requires that all bond proceeds (other than reasonably required reserve or replacement funds) be spent for the exempt purpose within three years after the date of issuance. Like the 30-day requirement, this arbitrary and inflexible rule will create serious obstacles for projects whenever ambitious schedules cannot be adhered to or unforeseen difficulties arise. In some cases, public hospitals are required by local laws or practice to adopt construction periods of longer than three years. NAPH believes that this three year requirement should also be eliminated or amended, either generally or for governmental hospitals in particular, to take into account this need for greater flexibility.

d. Restricting the Trade or Business Use of Governmental Bonds

Finally, H.R. 3838 would subject any portion of an essential function bond which is used by (or loaned to) a private business to the Statewide volume limitations, thus penalizing governmental entities which join with private business in activities benefitting the public. NAPH proposes that you eliminate the inclusion of any governmental bond proceeds under the Statewide volume caps applicable to quasi-governmental bonds.

2. Access to Capital for Public Hospitals

In addition to our specific concerns about H.R. 3838, we also have more general concerns about the future ability of essential providers of care to the poor to obtain access to capital. We hope we can count upon the members of this Committee to assist us to address both our short-range and long-range needs with regard to this issue.

a. Mortgage Insurance Under § 242 Of The National Housing Act

Three years ago, Congress adopted a bipartisan amendment to the 1983 Housing Act to make mortgage insurance under the FHA Section 242 program available to public hospitals, providing capital which is badly needed for renovations and construction by some of our nation's most essential providers of health care. Despite legislative action in 1983, 1984, and numerous letters and discussions, final regulations have not issued, and public hospitals which could proceed under existing regulations have not been permitted to do so.

In Section 104(f) of the Housing and Community Development Technical Amendments of 1984, Congress commanded that "the Secretary of Housing and Urban Development shall, not later than October 31, 1984, issue regulations to carry out the amendments made to Section 242..." As explained more painstakingly in the Statement of Managers of the Technical Amendments Conference Report (No. 98-1103 at 24):

> "To assure this insurance program is promptly implemented, the conferees direct the Secretary of Health and Human Services (HHS) to immediately begin accepting and processing applications from public hospitals for mortgage insurance with the expectation that regulations will be in effect by the time a final commitment is required." (Emphasis added.)

A notice of proposed rulemaking ("NPRM") at 49 Fed. Reg. 40,047 (October 12, 1984), made technical amendments to incorporate public hospitals into the current regulatory scheme. The comment period closed December 11, 1984. However, no final regulations have ever been issued. If regulations to bring public hospitals into the Section 242 program are not finalized soon, qualified public hospitals will not be able to obtain the mortgage insurance Congress intended to make available to them until 1987 -- four years after Congress directed that the program be expanded to insure public hospitals.

NAPH has proposed addition legislation that would require HUD to implement this bipartisan 1983 amendment -- through issuance of final regulations -- by a date certain. If regulations do not issue by such date, applications should then be processed, and insurance commitments issued, under existing regulations for non-public facilities. DHHS, which actually administers this program for HUD, believes it could process public hospital applications under current regulations. We therefore ask the members of this committee to support us in this legislative and regulatory effort as well.

2. Need For Future Institutional Support

Finally, we agree with those who maintain that it is not necessarily the role of the Medicare program to solve problems of equity and access to care for the non-Medicare poor. We do believe that Congress must ensure that "reforms" in Medicare and other current programs not unnecessarily or unintentionally damage or further erode the tenuous situation of hospitals providing such care. However, ultimately, access must be a responsibility assumed directly by governments at all levels -- including the federal level. In that regard, we hope that this committee will also work with us in the future to resolve our more basic needs. Public hospitals are an important part of America's urban infrastructure. With no sign of universal national health coverage on the immediate horizon, we must presume they will remain so. Given the substantial other changes that are occuring in our nation's health system today, we hope you will work with us on more direct programs to assist in the preservation of at least the core of that infrastructure.

Senator **Durenberger**. We do not have enough time this morning, I think, to adequately cover the kinds of costs of capital questions that I would like to ask all four of you so I would like to submit some specific questions in writing to all of you. And since you are not going to have a crack at the tax-writing side of this committee, please keep in mind what Dan Quayle suggested to us earlier in this hearing and that is that we up here have a responsibility on the capital issues that on the tax-writing side that may transcend what we are doing here today.

But today is our opportunity, your opportunity, everybody in this place opportunity, to input into that part of the process using this hearing as your vehicle.

As I recall what has happened to me between 1983 and 1986, in 1983 as we sat over there in the Ways and Means Committee conferencing the amendments for the Social Security Act, I was compelled by some of Dick Gephardt's logic to say, by gosh, if we don't tighten this up right now on the capital side, the hospitals are going to run out and spend like mad. And then I was persuaded somehow that if we tightened up enough on the 93-percent side, that we were putting into effect then, we wouldn't have to worry about hospitals running out on the 7-percent side and running up their costs.

I then, over a period of time, began to appreciate the fact that the general impact of prospectively pricing the operating side would have an impact on what hospitals did on the other side.

But then other factors came into play. I mean the cost of money started dropping in the marketplace. But not necessarily for everybody.

So we find ourselves now, I think, against a deadline. It is sort of like deciding whether you are for aid to the Contras or not because as of March 15 or some other magic date you have to make that decision. And so we have a deadline of June 2 in effect. If you believe what HHS told us—and the President believes it—that means on June 2 something is going to happen. We have got a June 2 deadline by which we have to make some decisions.

But the kind of decisions that we all need to make here in defining capital and defining the prospective pricing mechanisms include, first, the issue, I think, of for what, capital for what. And I tried to draw the distinction earlier between real estate and fixed capital investments and the equipment investments, the moveable investments, and try to put us in the shoes of the operator of a hospital. They are two very, very different things, particularly when you look at it in terms of the price of money for each of these is somewhat different. And then looking at where you go to get your money in terms of some people can use retained earnings or some other—or however you characterize that. And other people have to borrow against their equity. That leads you to an understanding, I think, that the value of hospital assets or equity is different today depending on where you are in this country, which line of business you happen to be in, and what your competition is.

So there are a lot of factors. The responsiveness of State and local governments. That varies all across the country. I mean, obviously, the subsidies are coming out of the system and in some areas, State and local governments are able to adequately pick up the slack and others they are not.

There is a variety of factors playing against the issue of capital that it strikes me we need to take into consideration. So maybe I am looking here for a brief observation from each of you about the importance of what we do in other areas as to what we do here in this prospective payment system, and then what we might keep in mind as we approach the prospective payment legislation that relates to some of these larger issues.

I will start with Jack, I guess. We will just go back in the order of presentations. And just give us a general piece of advice that says as you approach these other issues, these are the kinds of things you ought to be looking for and then promise to be more specific.

Mr. OWEN. I would be happy to do that, Senator. And I would assume that you would like that sometime in the next week.

Senator DURENBERGER. Yes.

Mr. OWEN. All right.

Senator DURENBERGER. As soon as possible, right?

Mr. OWEN. Yes.

Senator DURENBERGER. Mike.

Mr. BROMBERG. Let me make a couple of points, if I can, factually that strike me as either coincidental or deliberate. The capital addon under the administration proposal, we think, is about 6 percent at best. It is interesting that the market basket last year that you are not going to give us is about 6 percent, which means that the capital tends to pale in comparison to what you did to us on the 93 percent. And whether it is a public hospital that Larry represents or a handsomely profitable for profit that I represent or one in the middle, none of us are going to get very far in terms of maintaining or improving quality unless we have an operating margin to use for that purpose.

So it is not just the tax bill that makes all this pale. It is what you are doing to us on the budget side.

On the other hand, the point I want to make is this capital proposal will really, really hurt certain hospitals. And I do not think ownership has anything to do with it. It is going to hurt those hospitals no matter what you do. Like the one we brought in a couple of weeks ago to testify on the House side, which was a sole—not a sole-community provider, but it was a 130-bed rural hospital, the only one within 20 miles, 65 percent Medicare, making a 3-percent profit. It had filed for bankruptcy 10 years ago. One of our companies bought it and pumped in millions of dollars of capital. And the hospital is a great hospital. Everybody will say that to you. But it has got a 28-percent capital to operating cost ratio, and you could give it a 20-year transition and it would not help. And your seven is better than anything I have heard yet. And Senator Baucus may have one that is going to even be better, but it will not help those kinds of hospitals. And there are lots of them.

And I just want to make one other recommendation that Senator Baucus made. I don't like exception procedures because they get to be subjective, bureaucratic, political, and unfair. But I do think an outlier or an exception process that is formula based as opposed to human based might be acceptable. If we could work out some formula as we did with the outlier under operating which said hospitals that are a certain percent above the norm in terms of their past obligations should be treated differently, I think that would make a lot of sense. And we do not have one in our pocket, but we would be glad to work with you to try to come up with something.

Senator DURENBERGER. Mr. Cox.

Mr. COX. I have already made my one statement about the need not to subject advanced refundings to the State by per capita caps.

I would just reiterate what Mike said. The purpose of us running the numbers on that one facility was to emphasize that the capital proposals that we are discussing are no respecters of efficiency or sound business decisions. And we can each cite excellent hospitals that ought to remain, that are going to get clobbered by this proposal. And I bet we could identify hospitals that ought to go out of existence because of bad business decisions that will benefit greatly from a capital proposal.

So my only statement would be that as we move forward we need to move with a great deal of caution.

Senator DURENBERGER. Larry, before you respond, one of the concerns I didn't touch on in this rambling question, talk, or whatever it is, is that a lot of community hospitals, publicly owned in most cases—and particularly as I see it in my State and some other places—one of their major capital problems—and this is often a matter of scale. The small ones you see more than the parklands and the D.C. generals or whatever. They cannot afford to go out of business, or they cannot afford to change the nature of their business. And one of the particular sympathies that I have is I watch, say, this Maryland planning process over here and it costs money to change the nature of your business, and whether it is advanced refunding and these for profit or not for profit networking that can go on in certain parts of the country. One of the issues we seem to be missing on capital is providing some money to let people change the nature of their business. I see it in my small towns. They have a little hospital, I think, in Zumbrota, MN which 3 or 4 years ago put $1 million into the hospital, and today, one of those 65 percent Medicare, et cetera, et cetera, hospitals. It cannot survive. I mean no way.

But the facility is there. It is owned by the people of that community. And what the hell are they going to do? Even under my proposal, I don't think they can make it. And yet the community has an investment there and what are all of us—not only Medicare, but all of us—going to do to recognize that.

Mr. GAGE. Well, I think you have clearly identified a problem that I can't answer sitting here or probably even in 1 week. I think that if you go back to what is going to happen in the industry, I think that you are going to find a lot of hospitals that aren't able to change the nature of their business or at least to broaden the base of their activities. And that involves State health planning laws and other issues that have nothing to do with Medicare or even the Tax Code.

I think you are going to find that you can do things through the Tax Code, and you can do things in the Medicare Program, that will make it easier for these changes to happen. Hospitals have generally labored under many more restrictions and regulations, public and private, than other entrepreneurs in the health care industry. Even if they have some capital available and want to go into the ambulatory surgery business, or to do something else that broadens the base of the services they provide and improve their fiscal viability, they cannot, although their own medical staff can open the same facility down the road from them with many fewer restrictions. A level playing field is needed, and there are a number of things that probably can be addressed by this committee.

The Tax Code, I think, contains a number of incentives and disincentives. Particularly for example, you may want to look carefully at the limitations or restrictions of what you can do with the proceeds of tax-exempt financing, if you can get it in the future either as a governmental entity or as a private non-profit entity. We do make several suggestions for more flexibility in this area in our testimony. I think that you can have an impact with such changes on the level playing field.

I would also make a general observation that the worst thing you can do in this committee, assuming you are going to spend more than a few days debating the tax bill—and I suspect that you probably are—is to set yourselves an artificial deadline of June 2 for doing something about Medicare capital payments.

What you do in Medicare, frankly, is going to be affected to a large degree by what you do or don't do on the tax side, because access to capital, for public hospitals and for everyone else, is an extremely important aspect of capital financing. How you need to get paid for capital costs may well differ substantially depending on how you must finance capital projects, and how you finance such projects will depend on some decisions that you are going to make in the tax bill.

Senator **Durenberger**. Do you think we ought to wait until we get the conference report on the tax bill before we do——

Mr. **Gage**. I don't think you need to wait that long, but I would suggest that if you feel that you are not going to have enough time to spend between now and June 2 on Medicare capital issues, that you give serious consideration to some kind of postponement of that deadline with a restriction on what the administration can do by regulation in the interim period. And I am not for endless postponements or the kind of government by continuing resolution that we have had with some of our programs.

Senator **Durenberger**. Well, if we believe what Bob Helms said about the authority and the council's opinion, all we need to do is authorize the continuity of payments. He said that was the lever that we took away from them.

Mr. **Gage**. You may have to go a little further than that just to make sure things don't get done in the interim.

I have just one final comment on an exceptions or outlier process. And I recognize such a process is inefficient. In fact, I generally am sour on exceptions and adjustments these days simply because in the areas that are important to me they never seem to get implemented, and I have been involved in court battles over the last several years. Hopefully, we have a disproportionate share adjustment that is idiot proof this time around in the reconciliation act. But I can recall Senator Long sitting up here—I think it was the Work Fare Program—and waving a form. He said, I'm going to write this form into the statute in order to prevent them from refusing to implement this program.

So I do think in this area some kind of carefully crafted, idiot-proof exceptions or outlier process is going to be necessary. But you may have to write the form into the law.

Mr. OWEN. Senator, could I comment just on your last one because you added something since you gave me the opportunity on what to do with those hospitals?

Senator DURENBERGER. Yes.

Mr. OWEN. There are a couple of other things that I think we ought to look at. One is, for instance, the swing bed issue. We have been arguing this for a long time, and it seems to me that anything that prohibits a hospital from changing what it is doing right now—that ought to be freed up and allow them to do some other things.

The second thing, getting back to what Senator Baucus was talking about, and that is the small rural hospital, which has the high standby cost and it is going to be very difficult under any kind of thing that has come out of the Medicare prospective payment system with a drop in admissions, it is going to keep that hospital viable without some other kind of an approach to the standby capital cost that exists. And it seems to me that that is going to be equally important.

And the last comment, back to the tax thing, is that I hope from what we have heard if what they want to do in moving hospitals out from under the volume cap that you are rethinking about what you were talking about on any kind of limits on hospital bonds, Senator. We'd like to talk to you about that.

Senator DURENBERGER. The only problem there is that—I heard that from John Bradimas, too, when he came in and told me that NYU gets discriminated against when compared with either Harvard or Q&E and Sooney and all the rest of those organizations. Everybody wants to get out from under the cap because nobody wants to compete with everybody else and everyone has a priority interest.

But the debate we are in is if we are going to have a cap of some kind, what is more important, housing or hospitals or——

Mr. OWEN. Hospitals I would certainly——[Laughter.]

Senator DURENBERGER. I am sure you would.

Max?

Senator BAUCUS. Gentlemen, I was struck with the point that Mike Bromberg made; namely, whether you are private or public or whatever kind of hospital, there are going to be some hospitals that are going to be hurt by the administration's proposal.

I am wondering if you could tell us which hospitals those are. That is, is there some way to generalize why certain hospitals recently incurred such high capital costs compared to others? Does this have anything to do with size, anything to do with location, anything to do with patient mix, anything to do with anything? Or is that purely coincidental? That is, it just happens to be that some hospitals are incurring the greater, more recent capital costs than some others?

Mr. BROMBERG. Let me take a shot at that. I, personally, do not think it has anything to do with type of hospital size, geographic area or urban, rural or anything else. I think what it has to do with are a couple of things. One, we used to say 40 percent. I think it is now closer to 50 percent of all the hospital beds in America were built in the 1950's. Mostly—a lot of them, not mostly, but a lot of them Hill-Burton financed. That means that those hospitals are 35 years old today or 30 years old or 40 years old. I heard talk about a cycle before. The cycle for fixed capital cost to hospitals tends to be very lengthy.

When a hospital like that is in need of massive renovation, it is very similar to building a brandnew hospital. In fact, under price controls when President Nixon was in, they used to define 75 percent renovation as a new hospital and you would be exempt from controls for that reason.

So you are really talking about building a brandnew hospital. And it is just like building a new house. I mean you are going to have a tremendous capital load. And hospitals that have done it in the last 15 years or 10 years or 5 years are going to get hurt worse. And they might be small rural. It does not matter what they are. They might be big cities.

Then there is the opposite problem that Larry raised about the ones that need it but don't have the money to do it. But, clearly, the ones that get killed in the short term are those. And there is no way to fix it. That is our problem. The length of the transition is not enough for them. And that is why we would reiterate that old capital being left out of this bill as of some date is important. The only argument I have ever heard raised against doing that, which would really solve the problem for all these hospitals, is that, well, it is complicated and there would be 6,000—you would have to compute the 6,000 hospitals—what percentage of their capital is after a certain date—well, you know, that pales. We hear that this is supposed to be simplicity. It is one of the goals. We heard that 3 years ago, and just looking at those charts and the regs that have come out since, that is not simple—we do this every day for the tax laws. We do it for every business in the country. We figure it out. I think we can do it here in terms of what capital is committed before a certain date. That would help all those hospitals, I think, regardless of what they are.

Senator BAUCUS. Do the rest of you generally agree?

Mr. OWEN. Yes, generally, I would agree with what Mike has said. And hospitals are in different stages of their capital cycles. And I think he has explained that pretty well. And that is why ownership or where they are located really is not important.

Senator BAUCUS. I have a second question. What happens when you talk about this group of hospitals? Where are they going to make it up? Is it going to be reduced capital expenditure, reduced operating costs, shorter length of stay? How are these hospitals going to make it up? What are they going to be able to do? What are they going to do under the administration's proposal?

Mr. BROMBERG. We are a 60-percent labor-intensive industry. We are also a little capital intensive, and we are spending a lot of time on it. We are a labor-intensive industry. We have laid off 140,000 workers in the last 2 years. And if a manager has to look at what he has got to do to survive, the first place he is going to look is employees. You cannot just cut salaries. The best thing you can do is to cut workers; the same thing the Federal Government is going to do under Gramm-Rudman. But at this point in time, I think we have less fat than the Government.

Senator BAUCUS. Cutting employees?

Mr. BROMBERG. Cut employees is No. 1.

Senator BAUCUS. What is No. 2?

Mr. BROMBERG. No. 2 is postpone any kind of capital commitment that would increase your operating costs. And that is the worst thing you can do because most of it is new technology.

Senator BAUCUS. Do most of you agree that that is generally what is going to happen to this group of high capital cost hospitals?

Mr. OWEN. The next step is probably going to be cut access and then quality. That is what we are concerned about.

Mr. COX. I think it has to be recognized too that these capital costs are fixed costs. And you cannot—if you have obligated your facility to those bonds——

Senator BAUCUS. You are talking about future.

Mr. COX [continuing]. You cannot do anything in the facility to get under the cost.

Mr. BROMBERG. Up until a cougle of years ago, my answer would have been we will raise charges to everybody else, but we cannot do that anymore because the marketplace keeps saying no.

Senator BAUCUS. What should the standard be to determine quality in health care? How do you measure quality of health care? I mean as we go through this process, not only capital costs but lots of other decisions we make around here, we are always faced with the question of how does this affect the quality of health care. And the question we have is: What should the standard be? How do we measure quality health care?

And I am curious as to what guidance you could give us as to how we measure the quality of health care.

Mr. OWEN. Let me take a shot at it, Senator. You have got the Joint Commission on Accreditation which has been out there for a long time. It is a measurer of quality. The Federal Government uses them on the basis of Medicare participation, and it is something that any community can look at to see that that hospital remains accredited. It looks at noticia committee, the credentialing committee, the audit committees and all the things that are there. In addition to that, you have got the Medicare Program itself which is a requirement of state licensing accreditation and any other appropriates they have. And on top of that, they have the professional review organizations who are supposed to come in and give you——

Senator BAUCUS. I guess my question is: How are we to know, members of the committee? I guess what you are saying is if the hospitals go through appropriate accreditation and so forth that that is sufficient. Maybe that is the only answer. I was just wondering if you had a more precise idea that we can all look at and agree that that should be the standard.

Mr. GAGE. No, Senator, I think that since we are talking about capital, I think we have to look at the way the capital financing industry measures quality, which is by a hospital's Moody's and

Standard & Poor rating. I think that is something that you have to be especially careful about in this committee because those ratings almost always will reflect your financial strength, but financial strength does not by itself necessarily lead to high quality—or access to care for the poor.

I think the other thing that probably should be put on the table and discussed a little bit is the debate that has occurred this week over the report that was issued by the administration regarding Medicare death rates of hospitals, because I think that report revealed in very, very significant ways some of the potential flaws in trying to come up with a qualitative measure of outcome or success. I think that, frankly, this report has given us an opportunity that we might not otherwise have had to go to the NAPH members who were on that list of hospitals and ascertain why some of them might have been on this list, however flawed that study might have been. And we came up with some pretty staggering statistics.

One hospital noted that the average age of their Medicare patients who died was 82; that 90 percent of their Medicare admissions were through the emergency room; that their average number of diagnoses were four, five and six per patient. And you really can't measure the quality of care needed by such patients in simplistic ways. We have maintained all along that public hospital Medicare patients are older, sicker, and require more resources than the average Medicare patient with the same diagnosis.

Senator BAUCUS. Mr. Owen, I would like your quick reactions to a PRO PAC recommendation which was the same as the Montana Hospital Association. It is about different treatment between land and building capital cost phasein versus moveable. What is your reaction?

Mr. OWEN. Well, our reaction right off the top is that that is not a good way to go, and for two reasons. It can be done, but the two reasons basically are that if you are going to a theory of pricing, which is what we are going to hopefully, moving toward, and a price will be established, then it allows the hospital director to determine how he is going to use that money, whether it is going to be on technology or whether it is going to be fixed equipment or whether it is going to be on labor instead. And that is the name of the game. For instance, if you want to buy a pen and that pen is a dollar, you do not go to the store and say here is 80 cents for the operation, 10 cents for moveable equipment. They might use the 10 cents for the fixed equipment, which really is that this pen is a dollar, and it is a fair price; and you don't care whether they have it being made by robots or being made by people.

So that is one of the reasons, if you believe in that principle. And that is where we are going.

The second is a more political one, and that is if you split it, we are having enough trouble with budget cutting movement by the administration on capital already. If there are two parts for them to cut, we are going to have two plates instead of one. So down the road we are going to be fighting about how much we are going to get in moveable equipment, and then we are going to be fighting how much we get fixed.

So we would like to settle it once and for all, get it part of the price and get a fair price for it.

Senator **Baucus**. Thank you very much.

Senator **Durenberger**. Senator Bradley.

Senator **Bradley**. Thank you, Mr. Chairman.

First, let me commend you for not only the hearing but for your initiative in this area. I mean I do think that the administration's proposal was much too severe, and I think that your phasing in over a longer period of time makes a lot of sense. And I also think continuing hospital specific payments for a longer time is very important.

I must say I still have some concerns, though. Does the prospective system for capital penalize hospitals that are just completing large capital projects? I hope that we will get to questions such as these in the course of the hearings.

But I am very pleased that the hearings are taking place. And I am pleased that you have brought a sense of perspective to what the administration wanted to do, which I think is a little bit like shock therapy.

Now let me ask the panel; let me ask Mr. Owen in particular: As we look at how we are going to change this, should we reimburse old capital under the old system and use the reimbursement for new capital under the new system—do you think that would be a reasonable way to proceed?

Mr. **Owen**. I think it has got a lot of merit, Senator, especially the old capital being the 1983, prior to April 1, where the commitments were made and made in good faith, if those are included in and can meet the obligations that were made at the time when the hospital made this capital commitment under the rules of the game. The savings have got to come in the future where you can make management decisions, on capital decisions, in the future. So we would be much more supportive of a bill that included that older capital in there fully, and then started to look for anything that might be a savings coming at a future decision of how capital would be used.

Senator **Bradley**. Do other members of the panel agree?

Mr. **Bromberg**. Senator Bradley, at the risk of boring the chairman, I want to repeat one thing I said earlier which is that this committee has a history under the tax laws dealing with capital changes of always making them prospective in nature. I mean if you decide to repeal the investment tax credit this year, I am sure that few people on the committee would want to do it for capital committed under a prior law which held out the promise and the incentive of doing it. And that, I think, is the second reason for supporting Jack's position, which we do strongly, that a bill like Senator Durenberger's is a good bill if it applies to the future, but it would be very unfair to penalize hospitals that made huge commitments a few years ago under a different law. And I hope you would look at that.

Senator **Bradley**. Mr. Gage.

Mr. **Gage**. I would certainly agree with Jack and Mike and with your approach to old capital. I would simply add that when we were discussing this earlier with Senator Baucus that there are going to be classes of hospitals among them, including some large urban public hospitals, but not exclusively limited who are going to simply have no access to the capital markets in the future without some kind of assistance. The assistance is not going to be limited to Medicare, but I think there has to be some kind of outlier or exceptions process where such hospitals, however you choose to define them, for hospitals that have old physical plants that are essential, the hospitals, by some standard, and that we will be needing these capital investments in the future.

But it is not just a question of old capital for certain hospitals that will otherwise be shut out of the market.

Senator **Bradley**. Well, what do you think about the idea of any new system allowing the States the option of pooling the new amount of capital in their States so that they can apportion it to specific projects, hospitals?

Mr. **Gage**. You mean pooling the amount of new available capital and then making decisions with regard—that would affect Medicare reimbursement as well as——

Senator **Bradley**. As to which institutions are in need.

Mr. **Gage**. I would say that among the four people sittinq up here we are probably the most likely to support that kind of arrangement. But I would defer to the other members.

Mr. **Owen**. I would say, Senator, that we would be opposed to it. We would be opposed to it not on the basis of a concept. But right now, the only two States I know of who could do that would be New Jersey and Maryland with rate commissions. And what that would almost in effect require is some kind of a rate commission in every State because how would you determine who should get that money, who would the hospital go to see.

Senator **Bradley**. You mean what that would require is more efficient hospitals in every State.

Mr. **Owen**. Well, I am not sure it would require more efficient hospitals. It would require some bureaucracy in every State in order for the hospital to apply in order to do that. And I do not think we want to see that occur. It is fine in those States that have a waiver if they want to try and do it. I do not have an objection to that. But I would be opposed to it as a national policy.

Senator **Bradley**. All right. Thank you very much.

Senator **Durenberger**. Thank you very much.

Let me thank the panel for their contributions. One of the questions I am going to ask you to respond to in writing, of course, is the problem that I assume may be created by a continued passthrough, if we just continue to set something up where we——

Mr. **Bromberg**. Could I make one point, Mr. Chairman?

Senator **Durenberger**. Yes.

Mr. **Bromberg**. I don't think any of us are proposing cost reimbursement be continued. I think there are ways to work with you that can turn old capital into a prospective—hospital specific prospective.

Senator **Durenberger**. I think what we are going to ask you is: If we do an old capital versus new capital, how your members can game that kind of a system where there might be a disincentive to innovation. Those kinds of questions.

Senator **Bradley**. Mr. Chairman, may I submit some questions for the panel?

Senator **Durenberger**. By all means. You bet.

Thank you very much.

Senator DURENBERGER. Let me say the next panel is George Middleton, the chairman of the board of trustees, Alliance Health System, Norfolk, on behalf of the Association of American Medical Colleges; Ed Schwartz, hospital director, University of Minnesota on behalf of the Coalition for Fair Capital Reimbursement; Ron Kovener, vice president, Healthcare Financial Management; David Abernethy, president-elect, American Health Planning Association, and deputy commissioner of planning, policy and resource development, New York State Department of Health; and Kathleen Means, who I have referred to several times in a complimentary way already this morning, from Blue Cross and Blue Shield Association.

They are coming up there. Let me tell you that we have just estimated that if we keep going the way we are going we will finish here about 1:20. I have to preside at 1 o'clock so we are not going to finish at 1:20. With that, let me indicate to all 5 of you that your statements will be made part of the record, and you may proceed to summarize them in 5 minutes or less beginning with George Middleton.

STATEMENT OF E. GEORGE MIDDLETON, JR., CHAIRMAN, BOARD OF TRUSTEES, ALLIANCE HEALTH SYSTEM, NORFOLK, VA, ON BEHALF OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Mr. MIDDLETON. Mr. Chairman, I am an electrical contractor and you might perhaps want to know what I am doing here. I am the chairman of the board that you referred to earlier that has to live with all of this after everybody gets through with it.

I am chairman of a holding company that runs two hospitals. One is a tertiary care teaching hospital of 644 beds with all the things that go along with that. And the other one is a 256-bed hospital that we put up in the suburbs right on the city line so we could cater to that market out there. In addition to that, we run three urgent care centers, two nursing homes and our free-standing diagnostic radiology and physical therapy things, and also an HMO. So we have a little bit of a grip of what is going on in a number of markets.

I am sorry that Senator Baucus has left because I leave here today to go to southwest Virginia to talk to a group of sole-community hospitals. So I think that I have a fairly broad spectrum of what is going on as far as the layman is concerned. I am not a professional, and I will not speak as a professional. I will speak as one that has to live with what professionals come up with. Sometimes it is difficult.

I will say that the businessmen on my board and the boards that I have talked to about the country have been enthused with what has happened since the advent of prospective pricing and DRG's. We have seen hospitals for the first time in history come to grip with the things that we as businessmen have been coming to grip with for years. Hospitals are beginning to find out what things cost. They never knew that before. They are beginning to be efficient. They were never that way before.

I am not going to say exclusively that DRG's are good for everybody, but I can say that within the context of medical center hospitals, which is our hospital arm—in September 1984, we reduced our charges by 5 percent. We just submitted our budget for the coming years. We will have held those charges for 3 years. It is due mostly to the fact that we have become more efficient because we had to be.

So we as businessmen have welcomed the prospective payment system as it relates to operating costs. But, we also are concerned about what is going to happen to capital costs because we as businessmen get involved with that every day. We see over and over again the man that goes into business, recaps his operating expenses, recaps his general administrative overhead, makes a little bit of profit, but makes no provision for capital expenditures. Five, seven years down the road—he dies because his equipment wears out.

And so we are very interested as trustees as to what happens with capital. We are opposed to the administration's approach through regulation. We were, quite frankly, rather enamored with the Durenberger-Quayle approach—not completely enamored but quite enamored. We think that it addresses many of the situations that we think need to be addressed.

We took the numbers and we ran them as they applied to our hospitals. We find that through the administration's approach over a 7-year period this negative impact will be in the amount of $28,500,000. The Durenberger-Quayle approach over that same period of time will have a negative effect of $16,400,000. So we think that your approach, indeed, is headed in the right direction.

We would submit that perhaps it needs a little more massaging. You have a document that has been submitted to you that addresses these matters a little further.

We think that we need principally three things: One, legislation, not regulation; two, capital costs addressed realistically; and three, that teaching hospitals are a different animal from other hospitals and, consequently, have to be addressed differently. However, I have to say that this statement will address realistically and fairly not only teaching hospitals but hospitals across the board as I view them.

Thank you.

Senator Durenberger. Thank you very much.

[Answers to questions and the prepared written statement of Mr. Middleton follow:]

association of american medical colleges

March 27, 1986

Ms. Shannon Salmon
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Ms. Salmon:

The attached responses are furnished in follow up to the testimony E. George Middleton presented on behalf of the Association of American Medical Colleges at the March 14 hearing on capital payments. If you have any questions, please call me at 828-0493.

Sincerely,

James Bentley

James D. Bentley, Ph.D.
Associate Director
Department of Teaching Hospitals

cc: E. George Middleton
Glenn Mitchell

JDB/mrl

Attachment

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1. Your testimony indicates that AAMC would support splitting capital costs into components:

   1. moveable equipment; and
   2. fixed equipment and plant.

   Doesn't this approach add unnecessary complexity to an already complex system

All proposals for paying hospitals on a prospective payment basis for capital include quite complex calculations. For example, under S. 2121, hospital capital costs must be separated annually into three components: PPS units, exempt part units, and outpatient units. This separation must be made during both the transition and full implementation years. Separating out moveable equipment and immediately incorporating it into the DRG prices is a far less burdensome calculation than separating capital into three components each having separate payment rules.

2. Your testimony lists at least 10 hospitals that have just completed or are in the process of constructuring major plant additions. Since you oppose the Administration's planned 4 year transition, is seven years more acceptable to this group? As opposed to the Administration's proposal, what impact would a seven year transition have on the group?

As stated on page 13 of the AAMC testimony, a seven year phase-in is clearly preferable to a four-year phase-in; however, even a seven year phase-in substantially underpays hospitals which have major capital commitments for new facilities or major renovations. As a result, the AAMC advocates using a hospital specific transition period which recognizes the financial commitments of individual hospitals. Ideally, the AAMC favors using a base period capital concept and a hospital selected transition position. If this is unacceptable, the AAMC could support a hospital-specific transition approach which varies the length of the transition period with either (1) the percentage of a hospital's fixed assets which are debt financed or (2) the percentage of fixed assets presently depreciated.

STATEMENT

OF THE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Medicare Payments for Hospital Capital

Presented to the Subcommittee on Health
Committee on Finance
U.S. Senate

E. George Middleton, Jr.
Chairman, Board of Trustees
Alliance Health System
Norfolk, Virginia

March 14, 1986

aamc

Association of American Medical Colleges / One Dupont Circle, N.W. / Washington, D.C. 20036 / (202) 828-0490

The Association of American Medical Colleges, AAMC, which represents all of the nation's medical schools, 82 academic societies, and over 350 major teaching hospitals participating in the Medicare program, is vitally interested in proposals to change Medicare payment for hospital capital. As this subcommittee knows, the AAMC supported the concept of replacing cost reimbursement for hospital operating costs with a prospective pricing system. Since the enactment of that system, the AAMC has repeatedly appeared before this subcommittee to recommend refinements in the prospective pricing system which would more fully recognize legitimate differences in the costs of different hospitals. Some of those refinements have been made; others are still being debated. In this situation, where payments for basic operating costs do not fully reflect real differences in hospital costs, the AAMC recommends that any new payment system for hospital capital be approached with care and study. A new capital payment system must not be allowed to compound the weaknesses and inequities of the prospective pricing system for operating costs.

This AAMC statement on Medicare payments for hospital capital is organized into three sections. First, this statement reviews available data on the capital costs of teaching hospitals and concludes capital costs per unit of workload performed are higher in teaching than non-teaching hospitals. Second, this statement presents six principles for Medicare payment of capital costs which have been adopted by the AAMC's Executive Council. Third, this statement examines both the Administration and Durenberger/Quayle proposals.

CAPITAL COSTS IN MAJOR TEACHING HOSPITALS

When Congress adopted the Medicare prospective payment system, capital costs of hospitals were excluded from the prospective payment and continued on a cost reimbursement basis. The AAMC recognizes this exclusion does not reflect a

Congressional commitment to continuing cost reimbursement for capital: it does reflect the presently inadequate, conflicting, and occassionally surprising information on capital costs of hospitals.

One of the initial surprises in the government's analysis of hospital capital costs in the Medicare program was the finding, by the Office of the Assistant Secretary for Planning and Evaluation (ASPE), that capital costs in hospitals belonging to the Council of Teaching Hospitals (COTH) averaged 5.01% of total expenses while capital costs in non-COTH hospitals averaged 7.17%. Of equal significance was the ASPE finding that COTH members were consistently more heavily concentrated in the low capital cost categories, Table 1. Other ASPE analyses tended to corroborate the unexpected COTH/non-COTH differences in capital costs. As shown in Table 2, lower capital costs were also found in hospitals with CT scanners, pediatric/neonatal intensive care units, open heart surgery services, and Medicare case mix indices greater than 1.1.

Table 3 shows depreciation and interest expenses as a percentage of total hospital expenses for COTH and non-COTH hospitals for 1982. It should be noted that the interest expense percentage includes both interest paid on capital indebtedness and interest paid on working capital because the American Hospital Association's Annual Survey of Hospitals does not differentiate them. COTH members, as a group, report a lower percentage of expenses for both depreciation and depreciation plus interest. This is consistent with the ASPE findings.

In Table 4, depreciation and interest expenses for COTH and non-COTH hospitals are computed on a unit of workload basis using adjusted census days, adjusted patient days and adjusted admissions. Because depreciation and interest in the Annual Survey of Hospitals are reported on a hospital-wide basis, it is important to have a workload measure that represents both inpatient and outpatient services. The "adjusted data" provides a comprehensive measure of hospital workload by increasing actual inpatient workload by a hospital specific factor designed to convert outpatient services into inpatient workload equivalents. In both depreciation and interest expenses categories, COTH hospitals report significantly higher expenses per workload unit. This finding of higher capital costs per unit of workload but lower costs as a percentage of expenses is also supported when depreciation expenses for COTH and non-COTH hospitals are compared by census region, Tables 5 and 6. Thus, major teaching hospitals have significantly higher capital costs per unit of workload than other hospitals.

In the past decade, construction and financing expenses have increased rapidly. As a result, hospitals having older facilities and equipment have depreciation expenses based on lower construction costs and financing costs based on lower interest rates. Table 7 shows the standard financial ratio "average age of plant" in COTH and non-COTH hospitals. The average age of COTH hospitals is 7.4 years while non-COTH hospitals average 6.7 years. COTH hospitals are 12% older, on average, than non-COTH hospitals. Average age of plant is shown by census region in Table 8. In seven of the nine regions, COTH hospitals have older plant and equipment than non-COTH hospitals.

The data analysis clarifies somewhat the capital costs of teaching hospitals. Without fully explaining capital costs, the data suggest two independent factors are acting to influence the relative capital costs of teaching hospitals.

First, major teaching hospitals do have greater absolute capital expenditures per unit of workload than other hospitals. At the same time, COTH members have relatively smaller capital costs when capital costs are compared to total hospital expenses, at least for periods in the early 1980's. This finding has significant implications in evaluating capital payment proposals from the perspective of major teaching hospitals. Using historical data as an indictor of future relationships, the acceptability of a uniform capital "add-on" to the DRG payment system depends on major teaching hospitals receiving a percentage "add-on" computed using the total of basic DRG payments plus the resident-to-bed adjustment as the base against which the percentage is applied.

Second, the physical plant of COTH hospitals is, on average older than that of community hospitals. This implies that COTH hospitals are relatively under capitalized. If major teaching hospitals are to continue providing up-to-date technologies for diagnosis and care, major teaching hospitals are more likely to undertake major capital projects in the near term, a development which would raise their capital costs. This expectation is supported by Table 9 showing that COTH members, which have 18% of adjusted admissions, had 27% of the construction in progress in 1982. This suggests historical data, such as the 1981 Medicare data used by ASPE, may not accurately represent current capital expense patterns.

The current above average construction spending in COTH hospitals is further demonstrated in Table 10 where 1982 total construction expenditures for COTH and non-COTH hospitals are compared by census region and nationally. COTH members report higher 1982 construction expenditures per adjusted admission than non-COTH members. This expenditure pattern suggests that COTH hospitals view themselves as undercapitalized and are modernizing to alter this perception. As a result, relative capital costs in COTH hospitals can be expected to at least approximate those in non-COTH hospitals in the next few years.

In summary:

- o historical data which compares capital costs to total expenses have been misinterpreted by some to imply that major teaching hospitals have lower absolute capital costs than other hospitals

- capital costs per unit of workload performed are higher in major teaching than other hospitals
- Major teaching hospitals have older plants than other hospitals, and
- recently increased capital spending by major teaching hospitals may alter statistical relationships that existed in data collected in the 1970's and early 1980.

AAMC PRINCIPLES ON CAPITAL PAYMENT

Analysis has shown that major teaching hospitals have greater capital costs per unit of workload than other hospitals. Given this observation and the "lumpy" capital cycle of major facility projects, the AAMC Executive Council has adopted the following six principles as recommended policy on Medicare payment for hospital capital costs

I. THE AAMC SUPPORTS REPLACING INSTITUTIONALLY SPECIFIC, COST BASED RETROSPECTIVE PAYMENTS FOR CAPITAL WITH PROSPECTIVELY SPECIFIED CAPITAL PAYMENTS.

Continuing the present open-ended cost passthrough for capital seems unlikely because it is philosophically inconsistent with prospective payment, is perceived to stimulate capital expansion and an over-investment in capital goods, and is likely to be under-funded or capped as service benefits for current beneficiaries are weighted against facility investments for future beneficiaries.

II. THE AAMC SUPPORTS SEPARATING CAPITAL COSTS INTO TWO COMPONENTS -- (1) MOVABLE EQUIPMENT AND (2) FIXED EQUIPMENT AND PLANT.

This separation, which has historically been maintained in accounting records, recognizes that expenditures for movable equipment are constantly made by hospitals and that the useful life of the items purchased is generally rather short. Expenditures for fixed equipment and plant, on the other hand, tend to aggregate into more infrequent major projects which have a relatively long useful life. Given these different characteristics, different payment approaches may be used for movable equipment and for fixed equipment and plant.

III. THE AAMC SUPPORTS INCORPORATING CAPITAL PAYMENTS FOR MOVABLE EQUIPMENT INTO PROSPECTIVE PAYMENT USING A PERCENTAGE "ADD-ON" TO PER CASE PAYMENTS.

Because movable equipment purchases are a regular and ongoing component of hospital operations, no transition period or phase-in is required in order to include movable equipment in the per case price. Incorporating movable equipment into the prospective price would encourage managers to consider the relative advantages of capital and labor intensive alternatives. With both payroll costs and movable equipment incorporated into a single payment rate, a hospital would have the flexibility to select the labor-equipment mix most suitable to its particular circumstances.

IV. THE AAMC SUPPORTS A PERCENTAGE ADD-ON TO PER CASE PRICES FOR CAPITAL COSTS OF FIXED EQUIPMENT AND PLANT THAT IS NO LESS THAN MEDICARE'S CURRENT PERCENTAGE OF HOSPITAL PAYMENTS FOR FACILITIES AND FIXED EQUIPMENT PROVIDED THAT THE ADD-ON IS BASED UPON A PER CASE PRICE WHICH APPROPRIATELY

COMPENSATES TERTIARY CARE/TEACHING HOSPITALS FOR THEIR DISTINCTIVE COSTS.

In enacting the Medicare prospective payment system, Congress recognized that the operating costs of teaching hospitals are higher than those of non-teaching hospitals and included a resident-to-bed adjustment in the DRG payment to recognize this difference.

> This adjustment is provided in the light of doubts . . . about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents . . . The adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals. (Senate Report 98-23, p. 52)

Thus, the patient care costs of teaching hospitals are met by combining the base DRG payment with the resident-to-bed adjustment. The AAMC believes capital payments made to teaching hospitals should be computed as a percentage add-on to the combined DRG and resident-to-bed payments.

V. THE AAMC SUPPORTS A LONG-TERM, HOSPITAL-SPECIFIC TRANSITION FROM THE CAPITAL PASSTHROUGH TO PROSPECTIVE PAYMENTS FOR PLANT AND FIXED EQUIPMENT.

In considering capital costs for plant and fixed equipment, it must be recognized that different hospitals are at various points in their capital cycles: some have new plants with high construction and financing costs; others have old plants and low costs but need to rebuild. Given this variability, the transition period should be long enough to recognize current obligations and make adjustments for plant additions approved by health planning agencies and alterations/modernizations required by life safety codes and licensing and accreditation agencies.

> VI. THE AAMC SUPPORTS A TRANSITION PERIOD WHICH ALLOWS EACH HOSPITAL ITS CHOICE OF (1) COST REIMBURSEMENT FOR DEPRECIATION AND INTEREST ON ADJUSTED BASE PERIOD CAPITAL OR (2) A PROSPECTIVE PERCENTAGE ADD-ON THAT IS NO LESS THAN MEDICARE'S CURRENT PERCENTAGE OF HOSPITAL PAYMENTS FOR FACILITIES AND FIXED EQUIPMENT.

Under prospective payments, change is the order of the day. Hospitals are examining long-standing operational practices and altering those found inconsistent with the incentives and requirements imposed by the new payment system. While changes in daily operating practices may be difficult, the everyday nature of these activities provides numerous opportunities for changing practices. The construction and financing of major facilities offer less flexibility: planning the project and obtaining all necessary approvals is a multi-year effort, the asset itself has a long useful life, and the permanent financing often is for 15 to 30 years. As a result of these long term dimensions of major facility changes, the AAMC believes a change in capital payments must include adjustments honoring (1) the depreciation and interest originally anticipated for ongoing construction and recent plant additions; (2) new projects in the final planning stages; and (3) expectations of bondholders, lenders and donors.

Under this transition policy, a hospital could elect to be paid on a cost reimbursement basis (depreciation and interest) for existing capital, capital projects under active construction, and capital projects for which a certificate of need was sought prior to a given date. These "base period" capital costs would be increased only for mandatory life safety or accreditation requirements approved by a planning agency. Capital payments would not be increased for facility modernizations, expansions, or replacements undertaken after the base period. At any time during the allowed period, a hospital receiving depreciation and interest payments could elect to change and receive the prospective capital add-on to DRG payments. Once a hospital elected the prospective add-on, it could not subsequently receive payments based on depreciation and interest.

The AAMC recognizes that hospitals with above average capital costs will probably select the depreciation and interest option initially while hospitals with below average capital costs will select the percentage add-on from the beginning. This pattern of choice, which increases Medicare expenditures from 1 to 2%, will help ensure the continued viability of hospitals with recent or ongoing construction projects and maintain access to the capital market for hospitals generally. The small increase in expenditures is a reasonable price to pay for converting hospitals from a capital system based on recovery of past expenditure to one based on capital formulation and the prudent investment of capital assets.

CAPITAL PAYMENT PROPOSAL

To date, two capital payment proposals have been presented. The proposal developed by the Administration has been partially revealed in its budget documents. The proposal developed by Senators Durenberger and Quayle has been fully and publicly presented in the Congressional Record. The AAMC thanks both of the sponsoring senators for this openness. The balance of this testimony comments on each of these proposals.

The Administration Proposal

The Administration's proposed budget for fiscal year 1987 advocates implementing a new policy for Medicare capital payments by regulation rather than legislation. The AAMC is strongly opposed to changing Medicare capital payments by regulation. A new capital policy necessarily involves balancing conflicting viewpoints and impacts. While the regulatory process includes an opportunity for public comment, the comments are often ignored and decisions on critical choices are made in closed meetings. The legislative process is preferred because it is more open and public. To ensure that the legislative process has an opportunity to consider a new capital payment policy;

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES STRONGLY RECOMMENDS THAT THIS SUBCOMMITTEE ADOPT LEGISLATION PROHIBITING THE SECRETARY OF HHS FROM MAKING CHANGES IN THE PRESENT CAPITAL PASSTHROUGH UNTIL CONGRESS ENACTS LEGISLATION DIRECTING THE SECRETARY TO IMPLEMENT A SPECIFIC CAPITAL PAYMENT METHODOLOGY.

Unless Congress takes this action soon, HHS has announced it will propose a new methodology on June 1 and publish it in final form on September 1.

Considering the specific features of the Administration's planned proposal, the AAMC has a number of concerns. First, if a percentage blend of hospital-specific and Federal components is to be used as the transition mechanism, the AAMC believes the phase-in should be across 10 years. The four year phase-in discussed by the Administration will have major adverse impacts on hospitals just completing or presently constructing major plant additions. Major teaching hospitals which would be harmed by this approach include:

The Presbyterian Hospital in the City of New York
The Mount Sinai Hospital, New York City
Temple University Hospital, Philadelphia
The University of Virginia Hospitals
The University of Michigan Hospitals
The University of Minnesota Hospitals and Clinics
St. Louis University Hospitals
Parkland Memorial Hospital, Dallas
University Hospital, Seattle
Stanford University Hospital,
and more.

Each of these tertiary care/teaching hospitals has just completed or is constructing a major facility which has required years to plan and approved by the certificate of need authority. In no sense have these hospitals "gamed the system" in anticipation of a future Medicare payment policy. Failure to recognize their increased capital costs could undermine the hospital's solvency and its ability to serve Medicare patients in the future.

Secondly, the AAMC is concerned that the Administration plans to use 1983 data for the Federal component. This base period does not include numerous capital projects which were underway before prospective payment began. The proposal compounds this shortcoming by using an update factor which reflects primarily the cost of borrowed capital, including working capital, and excludes the value of new capital. Use of this national index also precludes giving adequate consideration of regional differences in construction costs. To avoid these weaknesses,

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES RECOMMENDS THAT THE FEDERAL COMPONENT FOR COMPUTING CAPITAL PAYMENTS FOR A PHASE-IN TRANSITION BE BASED UPON ACTUAL 1986 MEDICARE CAPITAL PAYMENTS UPDATED ANNUALLY FOR INCREASED CONSTRUCTION AND BORROWING COSTS.

The Association is also concerned about the hospital-specific component that would be used for the percentage phase-in. By specifying that the hospital use the lesser of actual costs or adjusted base period costs, the Administration's proposal will penalize hospitals opening new projects. Many of the major plant replacements in major teaching hospitals are being built only after careful study and planning agency approval. Having behaved in a socially responsible way, the executives of the hospitals now find their hospital will be penalized financially. To ameliorate this inappropriate impact,

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES RECOMMENDS THAT THE HOSPITAL-SPECIFIC COMPONENT FOR COMPUTING CAPITAL FOR A PHASE-IN TRANSITION BE BASED UPON EACH HOSPITAL'S ACTUAL CAPITAL COSTS FOR THAT CURRENT YEAR.

The Durenberger/Quayle Proposal

The AAMC appreciates the efforts Senators Durenberger and Quayle and their staffs have made to listen to the concerns of hospitals. While the AAMC continues to favor an individual hospital phase-in, the formula phase-in of

S.2121 is a significant improvement over S.1559. The calculation of the capital costs is more clearly stated and the hospital-specific component demonstrates a concern for recently built and rebuilding hospitals. The Association does have four specific concerns with S.2121.

First, the AAMC believes a seven-year phase-in is still too short for hospitals with major plant replacements. For major construction projects, a useful life of 40 years is often used and 30 year loans are common. To recognize the problem of a fixed phase-in,

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES RECOMMENDS CONSIDERATION OF A HOSPITAL-SPECIFIC TRANSITION APPROACH WHICH VARIES THE TRANSITION PERIOD WITH EITHER (1) THE PERCENTAGE OF A HOSPITAL'S FIXED ASSETS WHICH ARE DEBT FINANCED OR (2) THE PERCENTAGE OF FIXED ASSETS WHICH ARE PRESENTLY DEPRECIATED.

Secondly, the AAMC believes S.2121 provides the Secretary of HHS with too much discretion in selecting base year periods and inflation update factors. Within the language of S.2121, the Secretary could implement many of the OMB budget cutting distinctions that the sponsors of S.2121 opposed in their statements introducing the legislation. Therefore,

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES RECOMMENDS SPECIFYING THE BASE YEAR AND THE SPECIFIC UPDATE FACTORS IN THE LEGISLATION.

Third, while the AAMC believes the decision to offset interest earned on funded depreciation is poor public policy and harms the credit worthiness of hospitals, the Association believes the language in the draft bill is overly broad. The bill states, ". . . any capital-related interest expense shall be offset with interest income from any source" (emphasis added). As a result, interest earned on operating funds, including working capital, would be offset. This, in effect, reduces the DRG operating payments by offsetting interest earned from cash on hand against capital payments. Therefore,

THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES RECOMMENDS THAT ANY OFFSET OF INTEREST EARNED BE LIMITED TO INTEREST EARNED ON FUNDED DEPRECIATION.

Finally, the language of S.2121 does not state clearly whether the effective date is (1) hospital discharges occurring on or after October 1, 1986 or (2) hospital fiscal years beginning on or after October 1, 1986. While the former provides a uniform national starting date, it has the disadvantage of seriously complicating the cost report for hospitals with fiscal years beginning on dates other than October 1, 1986. Therefore,

THE ASSOCIATION OF AMNERICAN MEDICAL COLLEGES RECOMMENDS THAT ANY EFFECTIVE DATE FOR A NEW CAPITAL POLICY BE BASED ON INDIVIDUAL HOSPITAL FISCAL YEARS.

CONCLUSION

Developing a new approach to paying for capital involves trying to solve two difficult problems simultaneously. First, hospitals must transition from a period of retrospective recovery of capital costs to a new era of a priori capital development formation. This takes time. Secondly, hospitals are at very differing points in a very "lumpy" capital cycle which is characterized by high costs when facilities are new and by low costs when facilities are old. This requires attention to hospitals at both ends of the cycle. To develop a new capital policy which preserves the financial viability of hospitals while treating them equitably will be most difficult.

If the Medicare system for paying hospitals for capital costs is to be changed, the AAMC believes great care should be taken before the change is made. The DRG system for paying operating costs was preceded by several years of research and a number of demonstration projects. No similar effort has been made for capital payments. In fact, the AAMC has yet to see the DHHS study on capital costs which is now overdue by more than a year. When that study and the Administration's recommendations are presented, the AAMC would welcome the opportunity to testify once again on Medicare payments for hospital capital.

Table 1

Percentage Distribution of Capital Costs as a Percentage of Total Expenses by Membership in the Council of Teaching Hospitals, FY 1981

	Percentage of Hospitals	
Percentage of Capital Costs	COTH	Non-COTH
Less than 4%	37%	25%
4% to 6.57%	39	34
6.58% to 9.99%	17	23
10.0% to 14.99%	6	13
15% to 19.99%	1	4
20% or more	1	2
TOTAL	101%	101%

Source: Office of the Assistant Secretary for Planning and Evaluation, DHHS.

Table 2

Capital Costs as a Percentage of Total Costs by Selected Hospital Characteristics, FY 1981

Hospital Characteristic	Number of Hospitals	Mean Percentage of Expenses for Capital Costs
CT Scanner		
Yes	1108	6.47%
No	3867	6.75
Pediatric/Neonatal ICU		
Yes	1215	6.09
No	3760	7.09
Open Heart Surgery		
Yes	463	6.09
No	4512	6.85
Medicare Case Mix Index		
Less than .9	862	5.64
0.9 - 1.0	1517	6.72
1.0 - 1.1	1631	7.16
More than 1.1	814	6.07

Source: Office of the Assistant Secretary for Planning and Evaluation, DHHS.

Table 3

Depreciation and Interest as a Percentage of Total Expenses for COTH and Non-COTH Hospitals, 1982

Expense Type	Percent of Total Expenses COTH Members	 Non-COTH
Depreciation	3.7%	4.2%
Interest	2.7	2.7
Depreciation and Interest	6.4	6.9

Source: AHA Annual Survey, 1982 data.

Table 4

Depreciation and Interest Expenses per Adjusted Census Day, Adjusted Patient Day, and Adjusted Admission in COTH and Non-COTH Hospitals, 1982

	Expenses per Workload Unit			
	Depreciation		Interest	
Workload Unit	COTH	Non-COTH	COTH	Non-COTH
Per Adjusted Census Day*	$8,596	$4,003	$4,345	$2,902
Per Adjusted Patient Day	23.50	10.90	11.91	7.95
Per Adjusted Admission	203.90	80.90	103.09	58.69

Source: AHA Annual Survey, 1982 data.

* A census day is equal to one bed occupied for 365 days. It is computed by dividing total patient days by 365.

Table 5

1982 Depreciation Expenses as a Percentage of Total Expenditures in Short-Stay, Non-Federal Hospitals by Membership in COTH and Census Region

	Depreciation as a Percentage of Total Expenses	
Region	COTH	Non-COTH
New England	3.5%	3.6%
Middle Atlantic	3.7	3.9
South Atlantic	3.8	4.3
East North Central	4.3	4.4
East South Central	4.3	4.4
West North Central	2.7	4.6
West South Central	3.9	4.3
Mountain	4.3	4.2
Pacific	2.9	3.9
National	3.7%	4.2%

Source: AHA Hospital Survey, 1982 data.

Table 6

Depreciation Expenses per Adjusted Admission in Short-Stay, Non-Federal Hospitals by Membership in COTH and Census Region

Region	1982 Depreciation Expense Per Adjusted Admission	
	COTH	Non-COTH
New England	$135.22	$ 86.94
Middle Atlantic	137.24	91.90
South Atlantic	133.45	88.02
East North Central	166.44	103.42
East South Central	128.87	77.13
West North Central	130.12	99.77
West South Central	122.68	81.93
Mountain	133.11	91.89
Pacific	128.57	111.08
National	$140.23	$ 92.93

Source: AHA Hospital Survey, 1982 data.

Table 7

Average Age of Plant in Short-Stay, Non-Federal Hospitals by Membership in COTH, 1982

Type of Hospital	Average Age of Plant*
COTH Hospitals	7.4 years
Non-COTH Hospitals	6.7 years

$$\text{*Average Age of Plant} = \frac{\text{Accumulated Depreciation}}{\text{1982 Annual Depreciation}}$$

Source: AHA Hospital Survey

Table 8

Average Plant Age in Short Stay
Non-Federal Hospitals by
by Membership in COTH And Census
Region, 1982

	Average Age of Plant*	
Region	COTH Hospitals	Non-COTH Hospitals
New England	8.74	8.16
Middle Atlantic	8.00	7.53
South Atlantic	7.04	6.19
East North Central	6.81	7.17
East South Central	7.32	6.22
West North Central	7.51	7.21
West South Central	6.74	6.01
Mountain	5.80	6.05
Pacific	7.74	5.99

*Average Age of Plant = $\frac{\text{Accumulated Depreciation}}{\text{1982 Annual Depreciation}}$

Source: AHA Annual Hospital Survey

Table 9

1982 Construction in Progress in Short-Stay, Non-Federal Hospitals by Membership in COTH

Type of Hospital	Percentage of Admissions	Construction in Progress	
		Amount	Percent of Total
COTH Member	18%	$1,603,593,494	27%
Non-COTH	82%	2,818,714,864	73%
Total		$4,422,308,358	100%

Source: AHA Hospital Survey

Table 10

1982 Construction Expenditures per Adjusted Admission in Short-Stay, Non-Federal Hospitals by Membership in COTH and Census Region

Region	82 Capital Expenditures Per Adjusted Admission	
	COTH	Non-COTH
New England	$307.44	$170.71
Middle Atlantic	368.39	274.83
South Atlantic	349.91	258.55
East North Central	505.27	255.66
East South Central	649.29	247.71
West North Central	637.46	237.17
West South Central	351.64	230.73
Mountain	520.81	248.97
Pacific	366.07	278.86
National	$421.50	$254.50

Source: AHA Hospital Survey, 1982 data.

Senator **Durenberger**. Ed Schwartz.

STATEMENT OF C. EDWARD SCHWARTZ, HOSPITAL DIRECTOR, UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC, MINNEAPOLIS, MN; ON BEHALF OF THE COALITION FOR FAIR CAPITAL REIMBURSEMENT

Mr. **Schwartz**. Mr. Chairman, thank you. We want to commend you also for holding these hearings between all of the parties involved. We have submitted our report.

I would only want to say that in addition to being from the University of Minnesota, I do represent the Coalition for Fair Capital Reimbursement, 12 institutions in 8 different States who are vitally threatened by the proposed regulations that have been introduced, and that may begin to answer some of the questions about how many and where are they. We are from the east coast to the west coast.

We, as an institution, I think, would only summarize the Minnesota predicament in this, the University of Minnesota, by noting to you and to members of the committee that our project was started in 1983 after 8 years of very public planning process. We achieved a certificate of need. We achieved a State legislation. And, ultimately, the approval of the investing community who bought the bonds on our project, which are to be paid for by our hospital out of our patient care revenue.

The proposal that has appeared before you in the regulations that have been introduced would not deny us reimbursement in the next 10 years under that bond financing of 68 percent of what we would have gotten from Medicare, which is a total of $49 million. And that is over the next 10 years; not over the 30-year period of our entire indebtedness. And they give you some idea of the impact.

You spoke earlier, Mr. Chairman, about a social contract that has been made. We sense very deeply that our project to replace only a part of our facility—and by the way, as a part of opening that, we have turned back 150 licensed beds, taken them out of circulation, out of our complement, to address in part the overbedding problem in our State of Minnesota.

Your proposal, Mr. Chairman, would have a less impact, denying us about 35 percent of the Medicare funding flow for capital cost that we otherwise would have received.

We think that there are certain very important things that you should do. And for the Coalition and our institution, I would take a rifle shot and say that we think that you have to provide us with an opportunity to restructure our debts. We, indeed, have already refinanced our project once in 1985 so we are part of that statistic. We saved Medicare 14 percent of what they otherwise would have had to pay, I might add, in so doing. We are talking about a capital life cycle of 30 years. You simply cannot adjust to that in a 4-year period of time. I think anyone would realistically say you would need at least half the part of the life of the cycle in order to meaningfully deal with the problem whether it is annual budgets or ones that exist over 30 years.

We think that the 1983 basing is a deliberate attempt to deny individuals who have legitimate projects already approved but have been under construction for that period of time access to repayment for moneys that they are rightfully due.

We think that institutions such as teaching hospitals, in addition to the adjustments that have been proposed for case mix, should have included also medical education and high technology adjustments to the factor.

Most importantly, Mr. Chairman, I would say from our perspective, the obligation of this committee, I think, should respond to what Senator Quayle earlier called the worst-case scenario. And that is that we would go ahead and implement the regulations that have been proposed.

Senate file 2121 does significantly address the problems that we have raised, but we feel it needs to go further in terms of the areas we have suggested. We look forward to working with you and with the members of the committee as we go forward.

Senator **Durenberger**. Thank you.

[The prepared written statement of Mr. Schwartz follows:]

STATEMENT
OF THE
UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON FINANCE
OF THE UNITED STATES SENATE
ON
MEDICARE REIMBURSEMENT FOR CAPITAL COSTS
MARCH 14, 1986

The University of Minnesota Hospital and Clinic (UMHC) appreciates the opportunity to testify before the Subcommittee on the subject of capital financing under the Medicare Program and to discuss the incorporation of capital-related costs into the Medicare Prospective Payment System (PPS). UMHC commends Senator Durenberger's initiative in commencing an early dialogue on this subject among Members of Congress, Administration officials, the health care industry and other interested parties. The time devoted by the Subcommittee to this issue is extremely important. At stake here literally may be the future of many of the Nation's finest teaching hospitals, which for decades have been an essential part of the foundation of the American medical care system. Although we recognize that health policy must change in accord with other national priorities, we believe that any change must be fair and equitable.

The University of Minnesota Hospital and Clinic is a major teaching hospital located in Minneapolis, Minnesota. UMHC today is almost seventy-five years old. From its inception, its mission has been to provide state-of-the-art health care to patients from all parts of the country, to provide clinical education to graduate and undergraduate students in medicine and the other health sciences, and to serve as a center for medical research. Over the years, UMHC has developed a broad range of health services that include a full range of inpatient and outpatient services in all medical specialty areas. This breadth of services includes complex, highly sophisticated tertiary care that is unavailable in community hospitals. At the present time, over half of the physicians who practice in the State of Minnesota are graduates of the University Medical School and significantly more than half received their residency training at the University. UMHC is clearly a cornerstone of the research and development component of the Minnesota health care system.

Although its complementary roles in education and research are equally critical to the fulfillment of its overall mission, UMHC is perhaps best known to the public for its outstanding patient care programs. Each year, tens of thousands of patients from the Minneapolis area, Minnesota, and throughout the Midwest and the country rely upon UMHC for medical care. Last year, UMHC provided 155,000 days of inpatient care to over 18,000 patients from across the country. As the nation's largest transplant center, UMHC is truly one of country's major providers of health care.

UMHC has one of the ten largest health sciences education programs in the country. Likewise, the health sciences research programs at the University of Minnesota have grown to the extent that UMHC is one of the largest health research centers in the Nation today. UMHC has played a prominent role in the development and testing of many new diagnostic and therapeutic protocols. Continued success in this area requires that UMHC provide contemporary and progressive facilities to support the closely intertwined functions of patient care, teaching and research with a team of academicians, clinicians, practitioners and students.

UMHC is also a member of the Coalition for Fair Capital Reimbursement and is also appearing on their behalf. Although just recently organized, the Coalition already includes some of the Nation's preeminent teaching hospitals -- specifically, Brigham and Women's Hospital, the University of Michigan Hospitals, Montefiore Medical Center (New York), Mount Sinai Medical Center (New York), the New York Hospital, the Presbyterian Hospital in the City of New York at Columbia-Presbyterian Medical Center, the Stanford University Hospital, St. Luke's-Roosevelt Hospital Center, the University of West Virginia Hospital, the University of Washington Hospital and the University of Virginia Hospitals, as well as UMHC.

The Coalition for Fair Capital Reimbursement represents hospitals which have a number of unique capital characteristics and public service attributes which we sincerely believe necessitate special attention as Congress formulates legislation to incorporate capital-related costs into PPS.

The following is a summary of some of the common features of the Coalition's membership:

All of the members of the Coalition are major teaching hospitals, with an average size of over 1,000 beds. Each member plays a highly important role in the health care delivery system of its community and the Nation.

Each is a recognized center of excellence for both secondary and tertiary care. In addition, each performs major education and research functions.

All of the members of the Coalition are in the process of undertaking major renewal projects that require substantial capital expenditures. Their renewal projects are necessary at this time because their facilities with an average age of 55 years are functionally obsolete, inadequate to their mission, and generally substandard. Typical of Coalition members is the substantial age of hospital structures that these projects are intended to renovate or replace. For example, the 50-year old physical plant at UMHC has suffered from numerous accreditation and safety code deficiencies so as not to be able to adequately support UMHC's patient care.

Due to the obsolescence of their structures, these major teaching hospitals are also at a critical point in the "capital cycle." Without major renovation/replacement projects, they simply cannot survive as major teaching hospitals. Because these institutions have delayed inevitable major capital projects for long periods, their need for these projects has now become acute.

For many of these projects, such as that at UMHC, construction was initiated prior to the enactment of PPS in good faith reliance upon the cost-reimbursement methodology existing at the time. In every case, the project has been necessitated by compelling need. For each of these projects, there were substantial expenditures such as architects', engineers' and consultants' fees, prior to the enactment of PPS.

Many of the members of the Coalition must honor commitments to make outlays for essential capital projects that, as a percentage of operating costs, are well in excess of the national average. Thus, after its project is completed, UMHC projects a ratio of capital costs to operating costs that is almost twice the national average for many years.

Each of the hospitals in the coalition will suffer significant losses in Medicare reimbursements under the Administration's proposal and Senate File 2121.

The unique situations of the hospitals in the coalition demonstrate that Congress must carefully consider the impact of their actions on certain major teaching hospitals of this country. A payment system that does not consider the unique roles and circumstances of these academic health centers could jeopardize their ability to fulfill the roles society has asked them to play, and because of the numerous and significant contributions of these hospitals to the advancement of the quality of health care, could threaten a very great proportion of the health industry.

SUBSTANTIAL SOCIAL CONTRIBUTION

Major teaching hospitals such as UMHC and the other Coalition members provide an essential public service to the Nation through their health care services. The contributions of these hospitals are unique because of both their enormous volume of patient care services and their advanced tertiary care services that are available only in a relatively small number of major teaching institutions. Hospitals like UMHC serve as essential backups to community hospitals for services typically available only in the major referral centers. Further, their education programs in the various medical specialties and subspecialties, as well as their contributions to the advancement of medical science and technology, are well-recognized. What will be available in the community hospital in the next decade will be developed in the large research centers today, and passed on to the community during the next several years.

The finest health care in the world is available in the United States due to this country's major teaching institutions. Indeed, these institutions are the essential foundation of the Nation's present and future health care delivery system. Although there are 1,500 teaching hospitals that are involved in graduate medical education, less than 100 of these hospitals train almost half the country's residents. These major teaching hospitals develop most of the innovations in medical care and train the country's physicians in the application of these new technologies and treatment techniques. Unless these institutions continue to play their research and development roles as they have historically, the future of health care in the United States would be unlikely to match the present record of medical progress and achievement.

As a major teaching hospital, UMHC has always been in the forefront of the quest for new and improved patient care services. Its nationally recognized programs in areas such as spinal cord injury, diabetes, oncology, anorexia nervosa, Neonatology, as well as cystic fibrosis and organ transplantation, demonstrate its importance in meeting health care needs in a large geographical area. These patient care service capabilities are dependent upon, and reflect, UMHC's mixture of outstanding medical and other health professionals, advanced training programs, a broad range of basic and clinical research, unique technological capabilities, and interaction among the various UMHC health sciences units.

UMHC and the other teaching hospitals make indispensable social contributions that must not be threatened by the methodology by which capital is integrated into PPS.

THE UMHC PROJECT IS ESSENTIAL TO REPLACE OBSOLETE STRUCTURES

UMHC is not just another hospital providing care to the people of the Minnesota region, rather it serves the unique role of being the core teaching facility for the discovery-oriented medical and health sciences schools. There are other fine teaching hospitals in Minnesota, but only UMHC serves as the site where the basic and clinical researchers come together to develop the new, the different, the improved life saving procedures and patient care patterns. The facility replacement project is necessary to afford this unique organization a building that is contemporary with modern medicine.

For many years, UMHC has been faced with obsolete, inadequate, and substandard facilities. Several buildings of the UMHC campus being replaced are over seventy years old, and planning for this specific project began as early as twenty years ago. In 1974, UMHC undertook an extensive facility study that provided a technical, detailed demonstration of the need for substantial facility improvement due to extensive space deficiencies, inadequate functional relationships, unmet environmental needs, and general impediments to efficient operation. By 1980, the UMHC facilities were determined to be inadequate from the standpoint of design, space, mechanical/plumbing/electrical systems, building codes, vertical transportation, and circulation for acute patient care and support activities. In fact, UMHC was frequently cited by the Joint Commission on Accreditation of Hospitals for serious deficiencies that required renovation in order to comply with accreditation standards. In addition, the structural, mechanical, and utility systems were incapable of accepting many new and needed types of equipment. Further, stopgap remodeling measures had proven to be inadequate and extremely expensive. UMHC was spending $2 - $3 million annually for such palliative measures. Accordingly, after an exhaustive study of renovation and replacement plans, in April 1980 a replacement program was adopted calling for a capital expenditure of $233 million.

Next, the UMHC project was subjected to an extremely rigorous certificate of need (CON) process. At each stage of CON review, UMHC was called upon to demonstrate a compelling need for the replacement facilities. Based upon the cramped and outmoded facilities, the CON for the replacement project was approved in December 1980. The project has also been subjected to rigorous legislative review by the State of Minnesota. In 1981, demolition and construction for the project began. Due to the major changes taking place in the provision of health care which were reducing admissions and average lengths of stay for inpatient services, in 1982 UMHC significantly reduced the size of the project, reducing the total project cost from $233 million to $126 million, for a savings of over $100 million. In December 1982, UMHC sold $157 million in hospital revenue bonds to finance the project which including interest during construction totaled $217 million. UMHC refinanced the bond debt in the Spring of 1985 to achieve further economies based upon lower interest rates and new financing vehicles. All of these actions were undertaken in good faith reliance upon the existing cost-based Medicare reimbursement system.

UMHC's situation is an example of the kind of case for which we would request that the Senate Finance Committee provide fair transition relief, as the Committee has typically done in comparable instances in the past in order to avoid inequities under PPS. The need for this project has been adequately demonstrated, financial commitments for the project have been made and the building is about to be made operational.

The Administration's proposal completely ignores and Senate File 2121 only partially addresses the circumstances and financial requirements that are associated with projects of this kind. None of the current proposals provide adequate payments to allow UMHC to repay its debt and provide for reasonable capital replacement in future years. Between 1988 and 1997, UMHC's capital costs will average 14.5% of total operating costs. Under the Administration's current proposal, Medicare payments for capital will be approximately 6.3% of operating costs in 1988 and will drop to approximately 2.8% of operating costs by 1992. The Administration's proposed capital payment system will represent a loss of over $49 million in Medicare reimbursements for UMHC by 1997. Senate File 2121, although less severe, will create a loss of over $27 million in Medicare capital payments between 1988 and 1997. These are extremely severe penalties to impose on hospitals who happen to have been unfortunate enough to be caught in the wrong window of construction time.

NEED FOR EQUITABLE TRANSITION RELIEF

There is general agreement that the incorporation of capital-related costs into PPS could be very harmful in the absence of reasonable transition rules. This will be true particularly with respect to the Coalition hospitals such as UMHC, which have undertaken large capital projects to replace existing structures that are obsolete and desperately in need of renovation. Simple national average cost per discharge add-on formulas threaten to redistribute limited funds from hospitals that presently must make substantial capital expenditures to those hospitals without this need. The risk of harm is especially great during the current period of financial pressure on major teaching hospitals which stems from such factors as reductions in support for graduate medical education, impending changes in the tax laws which could significantly change the availability of tax-exempt financing and increase capital costs, reductions in research funds, employer initiatives to cut health costs, and the growth of alternative delivery systems (e.g., HMOs, PPOs, and IPAs). Clearly at times like this a fair transition mechanism is warranted and it is imperative that Medicare pay its fair share of these acknowledged facility needs.

Provision must be made in any new Medicare payment system to recognize the unique circumstances of hospitals who have made significant capital commitments prior to the announcement of a new capital payment system for Medicare patients i.e., April 1983 and for hospitals who, by necessity, must replace their facilities during the transition period. UMHC had completed its planning and issued $157 million in long term bonds to complete its renewal project prior to the announcement of a new prospective payment plan by Congress in 1983. These commitments must be honored and all payors whose patients utilize these buildings and equipment must share their responsibility for payment of these commitments. This includes Medicare.

In addition to the need to develop special provisions for payments for capital projects committed prior to the announcement of a new capital payment system, the Administration's and Senate File 2121 proposals are designed around several assumptions which will create an inequitable payment system. The following areas in the respective proposals need to be adjusted to provide a fair and equitable payment system for capital costs.

HIGHER CAPITAL NEEDS IN TEACHING HOSPITALS

Analysis by the Association of American Medical Colleges(1) has indicated that historically, per unit of services, capital costs are higher in tertiary teaching hospitals than they are in non-teaching hospitals. The Administration's and proposed Senate File 2121 use a single average cost per discharge in computing the capital payment for all hospitals. The effect of this approach is to overpay the smaller, less acute facilities for capital, which will create windfall profits for those institutions, while underpaying the larger more acute facilities, which will leave these hospitals without adequate resources to pay their debt service and to provide for reasonable capital replacement funds. This outcome is extremely evident in the case of UMHC. As I mentioned previously, by 1992 under the Administration's proposal, Medicare will be paying about 2.8% as an add-on to the DRG for UMHC capital costs, when effectively UMHC's capital costs will be in excess of 14% of total operating costs. It is obvious that the averaging approach fails to recognize the above average capital costs of tertiary teaching hospitals and will have a major negative impact on hospitals such as UMHC. In addition, the present proposals force losses onto new facilities regardless of efficiency. Unlike operating costs, capital costs are substantially fixed costs and cannot be managed down without sufficient time once the commitments have been made.

(1) Capital costs in COTH hospitals, Bently, James D., Ph.D., 2/9/84.

Conversely, facilities with older assets will be reimbursed the average regardless of efficiency or need. The effect of the current proposals is to jeopardize the future of hospitals which have recently initiated or completed capital projects and may prolong the life of hospitals which are under-utilized by providing them the opportunity to use windfall capital payments to subsidize operating costs. Use of a national average add-on that is not based on a percentage of operating expenses for capital will erode the tertiary care teaching hospitals ability to continue to provide high quality medical care, education and medical advancements.

LONGER TRANSITION PERIODS

The transition period in the Administration's proposal is totally inadequate and although Senate File 2121 lengthens the transition period, it is still not long enough. Bond payment commitments, particularly those of hospitals with recently completed or in process construction, are usually at least twenty years in duration and many have lengthy non-call provisions which were devised to reduce overall interest costs. Without an adequate transition period, many hospitals, particularly those with new capital commitments, may be unable to meet the commitments to their bond holders. H.R.3838 and similar restrictions in tax exempt bond financing under consideration by the senate will exacerbate this problem by restricting a hospital's ability to issue tax exempt debt or to restructure its existing debt through advance refundings. This could create a situation of double jeopardy for hospitals by increasing its cost of capital and reducing its ability to lower its debt.

BASE YEAR

The Administration's proposal use 1983 as a base year for determining the prospective payment system capital costs. Although an inflation adjustment is made in this proposal, 1983 does not include many major capital replacement projects such as UMHC's which are not included in the capital costs until they are put into service and therefore are not included in the national 1983 base year for capital costs.

INTEREST INCOME OFFSET

The present proposals further reduce Medicare payments by offsetting interest income on reserve funds and charitable contributions and yet neither proposal guarantees an increase for medical technology advancement. Interest earned on depreciation funds and gifts is imperative to provide the funds to meet the increasing costs of advancing medical technology. By utilizing interest income on funded depreciation and gifts to offset interest expense, no funds would be provided for technological advancement.

UMHC recognizes that national health policy must reflect changing circumstances and we do not oppose the incorporation of capital payments into the prospective payment system. We do object to the current Administration's proposal and Senate File 2121 because we do not believe they create a fair and equitable payment system.

In order to create a fair and equitable payment system for capital we have five recommendations:

First, it is imperative that the Congress recognize extraordinary capital costs which hospitals have already incurred. Just as there are hospitals with unique operating cost needs recognized under the prospective system, such as sole community providers and cancer hospitals, there are also hospitals with unique capital needs that warrant special consideration. Congress must assure that the projects for which funds were obligated prior to April of 1983 are reimbursed fairly so that bond obligations can continue to be met by the hospitals in these circumstances. We support Senate File 2121 which proposes that Medicare payments for capital costs during the period of transition from a cost pass through payment system to a prospective payment system should be based on a hospital's actual capital costs, and at the end of the transition period all payments for capital costs would be made on a prospective basis.

We would recommend that the flat fee national average add-on per discharge be eliminated from these proposals and replaced with methodology which take high costs of tertiary care, medical education and medical technology into consideration. We believe Senate File 2121 which provides adjustments for medical education and case mix is a step in the right direction but does not adequately correct the problem. UMHC believes that a percentage add-on to the DRG rates adjusted for case mix and indirect medical education, based on the national average of capital costs to total operating costs, would remove the inequities of the flat rate add-on and at the same time sustain the same incentives and ease of administration that is sought by flat add-on rate proposals.

Second, we would recommend that the transition period be lengthened to allow hospitals the opportunity to restructure debt, utilize available optional call provisions and adjust to a new fund flow for capital. Since most long term financing involving a minimum of twenty to thirty years, we believe that a seven year minimum transition period is quite inadequate.

Third, UMHC believes that a base year calculation for the national rates should be determined using the current year data at the beginning of the transition period.

Fourth, we would recommend that provision must be made for the costs of advancing medical technology. If a medical technology add-on is not provided, then interest income on reserves and contributions should not be used as an offset to interest expense.

UMHC believes that if capital payments are to be included fairly in the prospective payment system they must be adequate and equitable or the present system should be continued. UMHC recognizes this issue is very complex and applauds the efforts of the Congress to fairly resolve the problem rather than allowing the regulatory agencies to use this as a quick deficit reduction measure which knowingly distributes the burden inequitably. Any new payment policy should be established by Congress. If Congress cannot agree by the October 1, 1986 deadline, we would hope that the current payment system would be continued until Congress reaches resolution on this issue.

CONCLUSION

In summary, as Congress explores methods to incorporate capital-related costs into PPS, we urge that fair and equitable transition rules be adopted to reflect the unique capital projects and extensive social contributions of UMHC and the other Coalition hospitals. The continued success of these major teaching hospitals should not turn upon the vagaries of each hospital's position in the capital cycle. Preeminent institutions should not be penalized for being old, and for taking responsible measures to upgrade their facilities.

UMHC and the Coalition are anxious to work with the Subcommittee to create viable transition rules for major national centers of medical service delivery, education and investigation. UMHC respectfully urges Members of the Subcommittee to proceed carefully on this issue and that the Subcommittee consider transition rules that will incorporate capital costs into PPS equitably. Deserving hospitals need to be allowed to adjust to a new method of health care financing in a way which will not disrupt and threaten this vital component of our health care system.

Senator DURENBERGER. Mr. Kovener.

STATEMENT OF RONALD R. KOVENER, VICE PRESIDENT, HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION, WASHINGTON, DC

Mr. KOVENER. I am Ronald Kovener, vice president of the Healthcare Financial Management Association. I am pleased to present our association's views concerning Medicare payment for capital cost and the prospective payment system.

In April 1984, HFMA's Capital Steering Committee issued its recommendations for a capital payment methodology. A copy of these recommendations is attached to our formal statement.

We endorse the views expressed by the prior panel. I would like to highlight five main elements of HFMA's recommendations on capital as they relate to S. 2121.

Capital costs for each hospital are relatively fixed, with commitments for capital spending made for long periods of time. Accordingly, hospital capital commitments, especially for plant capital, cannot change with changes in patient volume or in response to payment changes phased in over a short period. Further, each hospital has its own capital cycle. Some have recently incurred capital obligations far in excess of the national average. Other hospitals will need to replace their plant in a few years.

Because of the fixed nature of plant capital and hospitals varying capital cycles, HFMA believes the fair payment for capital must consider the circumstances of individual hospitals and include a long transition period. We favor transition of at least 10 years for plant-related capital to give the individual hospitals a chance to adjust to new rules.

Second, the current focus on budget savings may encourage consideration of proposals that cut capital spending. HFMA believes fair payment for capital must be divorced from budget-cutting objectives. Capital is a very small portion of total Medicare spending, and HFMA urges the subcommittee to support capital payments that are neither more nor less than would be spent under the current law.

Third, there is a wide variation in capital commitments and needs of individual hospitals. Payment methods that rely on the use of national averages may cause large redistributions of capital among hospitals. HFMA endorses the provisions of S. 2121 to use the most current available data to determine payment amount.

Fourth, any new capital payment methodology should eliminate any bias for hospitals to incur capital costs in preference to operating costs. HFMA believes such bias would be substantially reduced once the equipment portion of capital is incorporated into the payment rate.

And, finally, HFMA believes that hospital capital expenditures are already constrained under the present system. PPS discourages higher operating costs and capital spending generally leads to higher operating costs. Because of PPS, hospitals are now likely to postpone capital projects and limit capital spending. Many capital decisions now are for refinancing current debt rather than undertaking new capital projects.

Because the current system does constrain capital spending, HFMA concurs that there is no need to link capital payment with health planning, whether under section 1122 or certificate of need requirements.

This concludes our summary of our remarks which are in your file, and I will be happy to answer questions.

Senator DURENBERGER. Thank you very much.

[The prepared written statement of Mr. Kovener follows:]

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STATEMENT OF THE HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION (HFMA) TO THE SUBCOMMITTEE ON HEALTH COMMITTEE ON FINANCE UNITED STATES SENATE ON THE METHODOLOGIES FOR PAYMENT OF CAPITAL-RELATED COSTS UNDER MEDICARE

March 14, 1986

I am Ronald R. Kovener, Vice President, of the Healthcare Financial Management Association (HFMA). HFMA is pleased to present testimony regarding methodologies for payment of capital-related costs under Medicare's prospective price setting (PPS) system.

HFMA is a professional membership association composed of over 25,000 individuals in 74 chapters who share an interest in financial management of hospitals and other healthcare institutions. HFMA's members include representatives from all major types of hospitals; urban and rural, large and small, investor-owned and tax-exempt, teaching and nonteaching, freestanding and multiple facility. In addition, our membership includes public accountants, financial consultants, and investment bankers, as well as representatives of Blue Cross, commercial insurors, and others who pay for healthcare services. These are the individuals with primary responsibility for access to and use of capital and the fiscal health of hospitals and other institutional healthcare providers across the country.

HFMA has long been involved in the development of an appropriate Medicare capital payment methodology. In April 1984, HFMA's Capital Study Steering Committee issued its recommendation for a capital payment methodology (attached). It is important to recognize that the committee's recommendations have sound philosophical and technical underpinnings. While other specific methodologies may differ from this proposal, it is essential that these philosophical and technical characteristics be recognized and satisfied in whatever capital payment methodology is selected.

FAIR PAYMENT AMOUNTS

The most widely discussed capital methodologies provide for an integrated PPS payment rate that compensates for both capital and operating costs. Initially, a separate rate for capital would be developed, but that distinction would be eliminated over time. This rate would be based on averages of costs of all providers. This is similar to the approach being used for PPS operating payments. However, this use of national averages will not yield a fair payment amount because of the relatively fixed nature of capital and the differing composition and capital cycle of each provider.

Fixed Nature of Capital

Major portions of a hospital's capital costs are represented by commitments made for long periods of time. The buildings and equipment have long periods of usefulness and long periods of planning precede their aquisition. Furthermore, hospitals rely heavily on debt to finance their capital needs and require stable cash flows to satisfy debt obligations. These debt obligations generally are for periods of 25 to 30 years. These characteristics are much different from operating cost, which is variable to a high degree. The reality that capital commitments cannot change with increases in patient volume or in response to short range payment method changes must be recognized in any capital proposal.

Varying Capital Cycles

The second difference is that hospitals have varying capital cycles. Some providers may have recently replaced their plant and thus incurred fixed obligations far in excess of industry averages. Other providers may need new plant in a few years and, therefore, have current cost below the average but will soon have needs in excess of an average. The analysis done to date documents the wide variation in ratios of plant to operating cost which exist for very valid reasons.

Accordingly, HFMA believes that any payment method for capital should recognize the existence of both the fixed nature of capital and providers' varying capital cycles. Using industry average cost as a basis of payment rates will result in wide variations between cost and payment among hospitals.

While we believe hospitals can adjust their operations and decisions to allow immediate incorporation of equipment into PPS rates, a much longer transition than was used in PPS is vital for plant capital. The average length of capital commitments is 25 to 30 years. Cash flow required for debt service usually exceeds capital costs until at least the eighth year. Therefore, HFMA believes a heavy emphasis must be placed on current hospital-specific cost experience for plant capital for the first eight years of a transition period of at least 10 years. Average rates used in any transition blend must also be based on the most current industry data possible.

ADEQUACY OF PAYMENT AMOUNTS

Fair payment rates for capital must be divorced from budget-cutting objectives. HFMA recognizes that Medicare funding is limited, but would point out that capital is a very small portion of total Medicare expenditures. In 1984, estimated Medicare hospital capital-related payments totalled about $2.9 billion, compared to Medicare outlays for inpatient costs of about $36 billion, according to an analysis by the Congressional Research Service that was prepared for the Senate Finance Committee. Accordingly, we urge that aggregate expenditures for plant capital be neither more nor less than what would be spent if current law were continued. This "budget neutral" aggregate amount of spending, coupled with a heavy emphasis on current hospital-specific costs during a long transition period, would help prevent both extreme shortfalls or windfalls. Some portion of the aggregate payment amount might be segregated to safeguard hospitals with unusual past obligations or that receive inadequate payments to finance essential new capital projects.

DATA-BASED DECISIONS

Any method of incorporating capital into PPS must be based on data that takes into account the effect of the payment method on various types of hospitals. There are wide variations in the way capital is distributed among hospitals, and care must be exercised to prevent large, unnecessary, and unjustified redistributions of capital among providers. Limited data collected by HFMA indicates that the range of percentages of capital to operating costs is 1.9 to 19.4. Other data now being collected and analyzed by various parties demonstrates similar findings, and HFMA recommends that Congress study this data to determine whether such factors as bed size, teaching status, age, or location must be considered, in the development of a capital payment plan. Analysis of the effects of specific methodologies on individual hospitals and communities is also necessary. Until the answers to these questions are known, clear decisions cannot be made. We encourage you to make your recommendations based on thorough, accurate analysis of the effects of the various proposals you will consider.

INCENTIVES OF A NEW CAPITAL PAYMENT SYSTEM

HFMA believes that any new capital payment methodology should provide incentives for cost effective hospital management without a bias favoring either capital or labor expenditures. Under the current passthrough, for example, a hospital might choose to purchase an autoanalyzer to perform certain routine clinical laboratory tests rather than hire additional personnel. The autoanalyzer, a piece of moveable equipment, would be paid for through the passthrough, whereas adding more personnel would only increase operating costs -- which PPS discourages. There is a much more direct relationship between equipment-related capital costs and operating costs than between plant-related capital costs and operating costs. Therefore, we see no reason not to incorporate payments for equipment into an integrated rate that is appropriately increased to recognize these costs. However, we have concerns about incorporating plant capital because of the variations in plant costs among hospitals and the fixed nature of capital. We believe any capital vs. operating cost bias would be substantially removed if equipment capital were incorporated into the payment rate under PPS.

LINKAGE WITH SECTION 1122

Design of a system for Medicare payment for capital-related costs for most hospital inpatient services must recognize that capital-related costs are a relatively minor part of total Medicare annual expenditures, but at the same time are as vital to hospitals' continued existence as capital is to any enterprise. Although capital expenditures by hospitals are large, hospitals spend far more for labor and other operating costs. Adequacy of payments for operating costs is crucial. Providers have responded to the incentives of PPS to enhance overall productivity, efficiency, and effectiveness and to limit all hospital expenditures, including expenditures for capital. Because capital investment generally increases operating costs, PPS places hospitals at risk for both operating and capital decisions. There is no incentive to make capital expenditures if there is limited funding for operations. Because of PPS, hospitals are now likely to delay or cancel new capital projects, to curtail the size of essential capital projects, and to seek the lowest cost of financing capital assets if essential quality of care considerations permit.

Many argue that the current passthrough of capital costs creates an incentive for hospitals to increase capital spending. However, current experience does not support this concern. A very large portion of new debt is for refinancing. In the present period of low interest rates, many hospitals are refinancing their debt to reduce their capital costs. Current capital spending is not adding inappropriately to capacity or otherwise adding to healthcare costs.

For the reasons just mentioned, HFMA believes that capital costs under the present system are constrained. Accordingly, we see no need to link capital cost payments with health planning whether under Section 1122 or cetificate-of-need requirements.

CONCLUSION

To summarize HFMA's views, I would again stress the following points:

Hospitals have responded well to the incentives provided by PPS, and a change in capital payments is not essential to furthering these incentives. However, the wrong capital payment arrangement could undermine the achievements under PPS and endanger the fiscal health of hospitals. To achieve positive results, hospitals must be assured that capital payments are fair and not designed simply for budget-cutting objectives. Budget neutral aggregate capital expenditures will evidence the fairness of a new system. Rates based on broad averages redistribute payments inappropriately among providers and are undesirable. There must be heavy emphasis on hospital-specific cost experience in new payment rates. A long transition of at least 10 years is necessary to recognize the fixed nature of plant capital. The new methodology must substantially eliminate any bias for management's use of capital vs. operating cost. HFMA believes this would be substantially achieved once equipment is incorporated into the payment rate. Capital cost increases usually result in increased operating costs. Therefore, existing PPS constraints on operating costs sufficiently control capital expenditures and there is no need for linking capital cost payments with health planning. Further evidence of the effect of current constraints on capital is the fact that a large portion of new debt is used to refinance long-term debt, thus reducing both interest costs and payments by the Medicare program. This is a clear indication that the passthrough of capital cost does not create perverse incentives.

This completes my testimony. I will be happy to answer any questions the subcommittee may have.

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Senator DURENBERGER. David Abernethy.

STATEMENT OF DAVID S. ABERNETHY, PRESIDENT-ELECT, AMERICAN HEALTH PLANNING ASSOCIATION; AND DEPUTY COMMISSIONER, PLANNING, POLICY AND RESOURCE DEVELOPMENT, NEW YORK STATE DEPARTMENT OF HEALTH, ALBANY, NY

Mr. ABERNETHY. Thank you, Mr. Chairman. I am David Abernethy, president-elect of the American Health Planning Association and Deputy Commissioner for Planning, Policy and Resource Development of the New York State Department of Health. I was chairman of the AHPA Commission on Capital Policy, a group of distinguished experts which examined in detail the potential effects of various capital payment options on the health care delivery system.

We have copies of our report available, and I would urge you to review this careful analysis of the capital issue.

I also want to note in introduction that my comments today reflect the association's views on capital policy. Our view of health planning legislation is rather different. We support S. 1855, the Health Planning and Resource Allocation Act of 1986, which you have cosponsored. It is new, flexible legislation in support of the many nonregulatory health planning functions which remain critical regardless of the capital policy enacted by the Congress.

The ability of communities to analyze changes in services and access and to inform purchasers and consumers of the availability of cost effective delivery alternatives is an essential service that health planning agencies must continue to provide as any new capital policy is implemented.

The American Health Planning Association's effort to analyze capital policy is, in our view, the only effort to look at the effect of capital payment on the total health care delivery system and the communities it affects. All other groups have focused only on the potential effects on providers. As a result, it is our firmly held conviction that health care capital decisions must be responsive to the needs of communities. Capital policy, given its central role in shaping the health care system, must reflect that requirement.

I have attached to my testimony evidence from my own State of New York that clearly demonstrates that there is great variability in capital costs. For this reason, a fixed capital payment per admission will inadvertently reward some while penalizing other institutions. These rewards and penalties bear little or no relationship to a community's need.

Our data represents, I believe, the only 100-percent sample of actual data which has been presented to the subcommittee. This represents 1986 data and is up to date as of last week.

I would note in analyzing these data that there are, in fact, no discernible patterns as to who does well and who does poorly under a fixed add on.

In New York, the range in capital costs is from 1.44 percent of total costs to 29.9 percent. The high capital cost hospital is a small exurban hospital in Suffern, NY, and the low hospital is a mediumsized inner city hospital in New York City. There is apparently no pattern.

Some teaching hospitals do well; some do poorly. Some community hospitals do well; some do poorly. Some rural hospitals do well; some do poorly. Again, there is no pattern.

The other thing I have noted about the testimony thus far today is that each witness, in essence, implies a higher level of capital reimbursement to the hospital system. It is our position that it is not particularly necessary to provide more caoital to the hospital system. All of the proposals that have been made today are based in one sense or another or have implied that there is a need for a greater level of capital. That does not seem to be the case.

What does seem to be the case is that the system as a whole may be, in fact, over-capitalized. The problem is that individual institutions may be under-capitalized.

The American Health Planning Association urges the Congress to develop a comprehensive capital policy which is not limited to Medicare, has as a major component a Federal payment policy which inhibits over-building, improves distribution and takes into account the needs of hospitals serving the indigent; provide support for a stable and adequately funded State and local health planning system to ensure that community need and local perspectives are considered.

Let me note in closing that in enacting the prospective payment system for operating costs in 1983 Congress recognized the need to revitalize the professional review organizations as an essential check and balance on utilization quality and costs. It was acknowledged that a mechanism external to individual hospitals was needed to offset the perverse incentives created for institutional providers. An equally compelling need exists for an external decisionmaking system for capital decisions.

It is our view that a strong health planning activity can play that role.

Thank you, Mr. Chairman.

Senator DURENBERGER. Thank you very much.

[The prepared written statement of Mr. Abernethy follows:]

TESTIMONY OF
David S. Abernethy, M.P.H.

President-Elect
American Health Planning Association

Before the SUBCOMMITTEE ON HEALTH
FINANCE COMMITTEE
UNITED STATES SENATE

March 14, 1986

CHAIRMAN DURENBERGER, MEMBERS OF THE SUBCOMMITTEE:

Thank you for providing the American Health Planning Association an opportunity to present our views on Medicare payment for capital costs. I am David Abernethy, President-Elect of AHPA, and Deputy Commissioner for Planning, Policy and Resource Development, New York State Department of Health. I was chairman of the AHPA Commission on Capital Policy, a group of distinguished experts which examined, in detail, the potential effects of various capital payment options on the health care system. I have brought copies with me today and urge you to review this careful analysis of the capital issue. To my knowledge, ours is the only effort to look at the effect of capital payment on the total health care delivery system, and the communities it affects. All other groups have focused only on the potential effects on providers.

It is our firmly held conviction that health care capital decisions must be responsive to the needs of communities. Capital policy, given its central role in shaping the health care system, must reflect that requirement.

I have attached to my testimony evidence that clearly demonstrates there is great variability in capital costs. For this reason, a fixed capital payment per admission will inadvertently reward some, while penalizing other, institutions. These rewards and penalties bear little or no relationship to a community's need.

For example, a fixed capital payment of 7% will produce a 15.5% shortfall in 1991 for the Columbia-Presbyterian Hospital of New York City. Mount Sinai Hospital will experience a 14% shortfall. We urge Congress to carefully consider these facts.

Capital investment decisions represent the best opportunity to shape the health care delivery system of the future. Please keep in mind that capital expenditures, once made, cannot be easily adjusted. The amount of capacity needed by the hospital system is shrinking due in part to the introduction of the prospective payment system and the growth of HMOs and other managed health care systems. Although a fixed add-on is simple, it cannot target reductions in capacity. We need to manage the shrinkage across the health care system as a whole in order to ensure that limited health care resources are used as effectively as possible.

I would add that my comments today reflect how we believe capital policy should be structured. Our view of health planning legislation is quite different. We support S.1855, the "Health Planning and Resource Allocation Act of 1986," which Senator Durenberger co-sponsors. It is new flexible legislation in support of the many non-regulatory health planning functions which remain critical regardless of the capital policy enacted by the Congress. The ability of communities to analyze changes in services and access and to inform purchasers and consumers of the availability of cost effective delivery alternatives is an essential service that health planning agencies must continue to provide as the new capital payment policy is implemented.

AHPA urges that Congress develop a comprehensive capital policy which:

- is not limited to Medicare;
- has as a major component a federal payment policy which inhibits overbuilding, improves distribution, and takes into account the needs of hospitals serving the indigent;
- provides support for a stable and adequately funded state and local health planning system to ensure that community need and local perspectives are considered in capital decisionmaking;
- has incentives for phasing out facilities and services which are no longer needed;
- ensures that needed institutions and services have access to stable and predictable sources of capital;
- allows hospital management the flexibility to make capital decisions which do not adversely affect access or cost;
- permits the evaluation of new technologies in clinical settings and pays for such technologies once shown to improve outcomes or reduce costs;
- is cautiously implemented and carefully evaluated to avoid unwanted consequences and permit corrective action when needed.

Simply put, any approach to Medicare capital payment must have a mechanism for ensuring that the limited dollars available go where they are needed. The debate to date has been focused on institutional efficiency. We agree with the need for such efficiency, but also believe that the real issue in capital policy should be the efficiency of the total health care system and its responsiveness to a community's need for health services.

In enacting the prospective payment system for operating costs in 1983, the Congress recognized the need to revitalize the Professional Review Organizations as an essential check and a balance on utilization, quality, and cost. It was acknowledged that a mechanism, external to individual hospitals, was needed to off-set the perverse incentives created for institutional providers. An equally compelling need exists for an external decision making systems for capital decisions. A strong health planning activity can play that role.

Health planning has always had the unenviable mission of attempting to balance cost containment with the need for access to services. Even with shortcomings, it offers a process which should be an important component of Medicare policy. Health planning is the only remaining federally supported activity which seeks to achieve a balance for access.

The Commission which I chaired attempted to examine all of the basic capital payment options. In doing so, we focused on the effect each option would have on the receipt of health care by people. Keeping this in mind, I would like to comment on the advantages and disadvantages of each of the approaches we indentified.

A. Inclusion of Capital Costs in the DRG Rates

Prospective allowance systems of payment for capital may take a variety of forms. The option discussed most frequently is a fixed payment per admission, based upon national mean historical capital costs. The administration's FY 1987 budget proposal is to develop such a system by regulation. We think that is bad policy.

A capital allowance promises the greatest potential for controlling costs within a single institution. Because this approach removes many incentives in the existing system to overuse capital, the allowance approach provides incentives for hospitals to build at the lowest possible price and interest rates. For these positive reasons, the Commission I chaired recommended that movable equipment costs should be incorporated into the DRG rates.

We did not favor the cost of fixed assets being added to a prospective allowance system because of its negative influence on the availability of services and on access to services. An allowance system poses the biggest threat to availability and access, as it does not take into account either those hospitals with high capital costs due to recently completed construction projects, or those hospitals which have low capital costs because they have made no recent capital expenditures. These variations, which an add-on approach cannot adequately address, are not a function of efficient versus inefficient hospitals. Some hospitals, clearly needed by any definition, which had not made major capital investments in decades, have now made commitments to revitalize their physical plants to continue to deliver care in their communities. But it will cost money that will not be recognized in a simplistic formula approach.

Thus, without extensive transition provisions, and careful design, a capital allowance could have a calamitous outcome for some hospitals, without large savings for the total system. FOR THIS REASON, IF CONGRESS DECIDES TO INCORPORATE CAPITAL

INTO THE DRG RATES, IT MUST, AT A MINIMUM, GRANT STATES THE FLEXIBILITY TO OBTAIN WAIVERS TO ALLOCATE CAPITAL MORE EFFECTIVELY TO NEEDED INSTITUTIONS.

B. Continuation of the Current Cost-Based Payment System

Under this option, Medicare would continue to reimburse for capital on a retrospective cost basis, with proposed capital expenditures reviewed by local and state health planning agencies prior to the time a capital expenditure is made.

I include in this option an assumption of state capital expenditure reviews as a prerequisite. Without such reviews, continued cost based reimbursement is not a feasible or affordable option. With a streamlined and adequately funded capital expenditure review program, it is both a feasible and affordable approach.

For the first time in ten years we now have real data on the effect of eliminating capital expenditure reviews and restraints. Two states, Arizona and Utah, deregulated and eliminated capital expenditure reviews in early 1985 and late 1984, respectively. The results have been dramatic.

A recent study, "A Study of The Impact of Deregulation on Health Facilities in Arizona," prepared by the Arizona Department of Health Services provides the most comprehensive picture of the effects of combining cost based reimbursement with no regulatory restraint. In the period of deregulation--forty-one months for nursing homes and eight months for hospitals--Arizona has experienced unprecedented growth in health care facilities and steady increases in hospital and nursing home revenues.

Although I recommend that you review this study and be aware of the impact on nursing home costs, I will limit my comments today to what Arizona has experienced with hospitals. At the point of deregulation in March 1985, Arizona had 72 licensed nonfederal hospitals, operating at a statewide occupancy rate of 56.8%. In the eight months following deregulation, the state received 72 building permit applications for proposed hospital projects totaling $256 million. This includes 11 new hospitals and 1,640 new beds.

A cost reimbursement system with a strong capital expenditure review does have positive attributes. If one is concerned about the efficiency of the total hospital delivery system, as opposed to internal efficiency within a hospital, the cost reimbursement system with capital expenditure review provides a vehicle to increase the overall efficiency of the total system. It also gives states the ability to encourage capital expenditures for facilities serving high need populations.

C. Pooling of Capital Payments/Establishment of Limits on Capital

The effects of the pooling of capital reimbursement and the establishment of explicit limits upon the amount of new capital which can be consumed would be very similar. For this reason, they are discussed together.

Pooling is a system in which all capital payments in a region or state would be paid into a capital reimbursement pool. Capital would then be distributed by a state or regional authority to individual hospitals based upon their ability to compete effectively to provide those services deemed by the authority to be needed.

The existing structure of state and local health planning could be used as the base to develop such a system.

Under the capital limits option, a fixed limit could be placed on the total dollar value of certificates of need to be granted by review agencies. In both options, the amount of capital expended could be based on the amount which would otherwise be available under the current payment system or under a fixed allowance system.

The strongest argument in favor of these two options is that they have the theoretical ability to shrink the overall capacity of the system more than either of the other two options. Although they provide less incentive to individual hospital managers to shrink capacity within an institution, selection of either of these two options would allow the state or regional review authority to decide specifically which institutions should grow and which should not. It is also true that given the ability of these two options to limit capacity, they have the greatest potential for discouraging admissions increases. Moreover, unlike the other two options, these do not add to the incentive present under the DRG prospective payment system to increase admissions.

Another attractive feature of both the pooling option and the capital limit option is the effect on the cost of capital. Use of either of these options would reduce the cost of capital through reducing risk. In the case of the pool, access to reimbursement from the pool would be guaranteed by the decision to allow the institution to make the capital investment. In the case of the fixed limit, reimbursement would essentially be guaranteed once a share of the fixed limit had been allocated to that particular institution. Further, the competition for limited capital dollars induced by these two options would tend to increase the proportion of capital investments funded through equity as opposed to debt.

As you examine the payment options and their potential effects, I urge you to keep in mind a very important fact which kept surfacing in our Commission's deliberations. THE HEALTH CARE SYSTEM AS A WHOLE IS OVERCAPITALIZED, BUT INDIVIDUAL INSTITUTIONS ARE IN MANY CASES UNDERCAPITALIZED. This suggests to me that when it comes to capital investment decisions, health care institutions are not created equal. Capital policy must reflect this fact or else we risk doing great damage to the availability of essential health services.

This observation leads to the conclusion that whatever payment policy is adopted must be carefully designed to ensure it does not underpay needed institutions, overpay unneeded institutions, or increase unnecessary capacity. The regulatory approach proposed by the administration does not meet this critical test.

I strongly believe capital should be allocated through a mechanism which targets limited dollars for capital to projects needed by the community. Such a capital policy will assure that capital payments are reasonably consistent with need.

Thank you.

14-Feb-86

ESTIMATED 1986 CAPITAL AS A PERCENTAGE OF REVENUE

OPCERT	HOSPITAL NAME	TOTAL CAPITAL AS A PERCENT OF OPERATING	TOTAL CAPITAL AS A PERCENT OF TOTAL REVENUE	TOTAL CAPITAL & CONSTRUC. AS A PERCENT OPERATING	TOTAL CAPITAL & CONSTRUC. AS A PERCENT TOTAL REVENUE
3620000	ARNOLD GREGORY MEMOR	4.00%	3.85%	4.00%	3.85%
1427000	BERTRAND CHAFFEE HOS	3.09%	2.99%	3.09%	2.99%
0601000	BROOKS MEMORIAL HOSP	10.94%	9.86%	10.94%	9.86%
1401000	BUFFALO COLUMBUS HOS	3.78%	3.64%	3.78%	3.64%
1401001	BUFFALO GENERAL HOSP	24.84%	19.89%	24.84%	19.89%
1401002	CHILDREN'S HOSP (BUF	8.80%	8.09%	8.80%	8.09%
0226000	CUBA MEMORIAL HOSPIT	6.95%	6.50%	6.95%	6.50%
3103000	DEGRAFF MEMORIAL HOS	8.85%	8.13%	8.85%	8.13%
1401005	ERIE COUNTY MEDICAL	14.58%	12.72%	14.58%	12.72%
1801000	GENESEE MEMORIAL HOS	10.32%	9.36%	10.32%	9.36%
3154000	INTER-COMMUNITY MEMO	3.07%	2.98%	3.07%	2.98%
0602000	JAMESTOWN GENERAL HO	14.43%	12.61%	14.43%	12.61%
1404000	KENMORE MERCY HOSPIT	5.08%	4.83%	5.08%	4.83%
1401007	LAFAYETTE GENERAL HO	1.96%	1.92%	1.96%	1.92%
0663000	LAKE SHORE HOSPITAL,	7.88%	7.31%	7.88%	7.31%
3101000	LOCKPORT MEMORIAL HO	28.75%	22.33%	28.75%	22.33%
3622000	MEDINA MEMORIAL HOSP	5.06%	4.81%	5.06%	4.81%
0228000	MEMORIAL HOSP WF&GF	3.98%	3.83%	3.98%	3.83%
1401008	MERCY HOSPITAL OF BU	9.25%	8.46%	9.25%	8.46%
1401009	MILLARD FILLMORE HOS	9.29%	8.50%	9.29%	8.50%
3121000	MOUNT ST. MARY'S	4.89%	4.66%	4.89%	4.66%
3102000	NIAGARA FALLS MEMORI	8.12%	7.51%	8.12%	7.51%
0401001	OLEAN GENERAL HOSPIT	6.64%	6.23%	6.64%	6.23%
1402000	OUR LADY OF VICTORY	12.92%	11.44%	12.92%	11.44%
1401010	ROSWELL PARK MEMORIA	5.26%	5.00%	5.26%	5.00%
1401011	SAINT FRANCIS OF BUF	5.75%	5.44%	5.75%	5.44%
0433000	SALAMANCA HOSPITAL D	8.31%	7.67%	8.31%	7.67%
1401006	SHEEHAN MEMORIAL EME	17.70%	15.03%	17.70%	15.03%
1403000	SHERIDAN PARK HOSPIT	4.20%	4.03%	4.20%	4.03%
1401013	SISTERS OF CHARITY H	7.17%	6.69%	7.17%	6.69%
0401002	ST. FRANCIS HOSP. (O	8.21%	7.59%	8.21%	7.59%
1801001	ST. JEROME HOSPITAL	10.53%	9.53%	10.53%	9.53%
1455000	ST. JOSEPH INTERCOMM	6.55%	6.15%	6.55%	6.15%
0427000	TRI-COUNTY MEMORIAL	8.55%	7.87%	8.55%	7.87%
0632000	WESTFIELD MEMORIAL H	16.35%	14.05%	16.35%	14.05%
0602001	WOMANS CHRISTIAN ASS	7.63%	7.08%	7.63%	7.08%
6027000	WYOMING COUNTY COMMU	5.77%	5.46%	5.77%	5.46%
	TOTAL WESTERN				
0701000	ARNOT-OGDEN MEMORIAL	6.48%	6.09%	6.48%	6.09%
5002000	BETHESDA HOSPITAL	7.24%	6.75%	7.24%	6.75%
5001000	CORNING HOSPITAL	4.56%	4.36%	4.56%	4.36%
5022000	IRA DAVENPORT MEM. H	3.66%	3.53%	3.66%	3.53%
4823000	SCHUYLER HOSPITAL	9.43%	8.62%	9.43%	8.62%
5002001	ST JAMES MERCY HOSP.	6.15%	5.80%	6.15%	5.80%
0701001	ST JOSEPHS H. ELMIRA	4.92%	4.69%	4.92%	4.69%
	TOTAL FINGERLAKES				
4401000	A BARTON HEPBURN HOS	7.10%	6.63%	7.10%	6.63%
3701000	ALBERT LINDLEY LEE H	4.07%	3.91%	4.07%	3.91%
0501000	AUBURN MEMORIAL HOSP	3.83%	3.68%	3.83%	3.68%
4429000	CANTON-POTSDAM HOSP.	5.70%	5.39%	5.70%	5.39%
2238001	CARTHAGE AREA HOSPIT	7.78%	7.22%	7.78%	7.22%
3202000	CHILDERNS HOSPITAL &	8.82%	8.10%	8.82%	8.10%
4458000	CLIFTON-FINE HOSP.	6.95%	6.49%	6.95%	6.49%
2625000	COMM. MEM. HOSP.-MAD	12.18%	10.86%	16.36%	14.06%
3301000	COMMUNITY-GENERAL HO	8.36%	7.72%	8.36%	7.72%
1101000	CORTLAND MEMORIAL HO	9.53%	8.70%	9.53%	8.70%
3301008	CROUSE-IRVING MEM. H	10.84%	9.78%	15.06%	13.09%
4423000	E.J. NOBLE-GOUVERNEU	7.85%	7.28%	7.85%	7.28%
2221000	EDWARD JOHN NOBLE (A	7.84%	7.27%	7.84%	7.27%
3202001	FAXTON HOSPITAL	17.12%	14.62%	17.12%	14.62%
2201000	HOUSE OF GOOD SAMARI	9.23%	8.45%	9.23%	8.45%
2424000	LEWIS CO. GEN. HOSP.	7.18%	6.70%	7.18%	6.70%
2129000	LITTLE FALLS HOSP.	7.81%	7.24%	7.81%	7.24%
4402000	MASSENA MEM. HOSP.	4.12%	3.96%	4.12%	3.96%

14-Feb-86

ESTIMATED 1986 CAPITAL AS A PERCENTAGE OF REVENUE

OPCERT	HOSPITAL NAME	TOTAL CAPITAL AS A PERCENT OF OPERATING	TOTAL CAPITAL AS A PERCENT OF TOTAL REVENUE	TOTAL CAPITAL & CONSTRUC. AS A PERCENT OPERATING	TOTAL CAPITAL & CONSTRUC. AS A PERCENT TOTAL REVENUE
2201001	MERCY HOSP. OF WATER	9.70%	8.84%	9.70%	8.84%
2101000	MOHAWK VALLEY GEN HO	7.19%	6.71%	7.19%	6.71%
2601000	ONEIDA CITY HOSPITAL	6.10%	5.75%	6.10%	5.75%
3702000	OSWEGO HOSPITAL	2.89%	2.81%	2.89%	2.81%
3201000	ROME HOSP. & MURPHY	6.12%	5.77%	6.12%	5.77%
3202002	ST ELIZABETH UTICA	11.26%	10.12%	11.26%	10.12%
3301003	ST JOSEPHS HOSP HEAL	5.36%	5.08%	5.36%	5.08%
3202003	ST LUKES MEM. HOSP.	10.23%	9.28%	10.23%	9.28%
3301007	STATE UNIVERSITY UPS	6.93%	6.48%	6.93%	6.48%
5401001	TOMPKINS CO. HOSPITA	14.30%	12.51%	14.30%	12.51%
	TOTAL CENTRAL				
0824000	CHENANGO MEMORIAL H.	5.25%	4.99%	5.25%	4.99%
0301001	OUR LADY OF LOURDES	7.24%	6.75%	7.24%	6.75%
5320000	TIOGA GENERAL HOSP.	10.13%	9.20%	10.13%	9.20%
0303001	UNITED HEALTH SERVIC	10.33%	9.36%	10.33%	9.36%
	TOTAL NY PENN				
1221000	A.L. & O.B. O'CONNOR	3.16%	3.07%	3.16%	3.07%
4521000	ADIRONDACK REGIONAL	5.49%	5.21%	5.49%	5.21%
0101000	ALBANY MEDICAL CENTE	6.91%	6.46%	6.91%	6.46%
1624000	ALICE HYDE MEMORIAL	4.37%	4.19%	4.37%	4.19%
2801000	AMSTERDAM MEMORIAL H	5.35%	5.08%	13.31%	11.75%
3801000	AURELIA OSBORN FOX H	9.88%	8.99%	9.88%	8.99%
4652000	BELLEVUE MATERNITY H	12.63%	11.21%	12.63%	11.21%
0901001	CHAMPLAIN VALLEY PHY	6.30%	5.92%	6.30%	5.92%
0101002	CHILD'S HOSPITAL	11.05%	9.95%	11.05%	9.95%
0102000	COHOES MEMORIAL HOSP	8.13%	7.52%	8.13%	7.52%
1001000	COLUMBIA MEMORIAL HO	6.24%	5.87%	6.24%	5.87%
4720000	COMMUNITY - SCHOHARI	13.24%	11.69%	13.24%	11.69%
1225000	COMMUNITY HOSP (STAM	5.72%	5.41%	5.72%	5.41%
1229000	DELAWARE VALLEY HOSP	27.99%	21.87%	27.99%	21.87%
1521000	ELIZABETHTOWN COMMUN	13.61%	11.98%	13.61%	11.98%
4601001	ELLIS HOSPITAL	8.84%	8.12%	8.84%	8.12%
5725000	EMMA LAING STEVENS H	11.50%	10.32%	11.50%	10.32%
1623000	GENERAL-SARANAC LAKE	3.80%	3.66%	3.80%	3.66%
5601000	GLENS FALLS HOSPITAL	12.24%	10.90%	12.24%	10.90%
1702000	JOHNSTOWN HOSPITAL	5.74%	5.43%	5.74%	5.43%
4161000	LEONARD HOSPITAL	5.91%	5.58%	5.91%	5.58%
3824000	M.I. BASSETT HOSP.	6.21%	5.85%	6.21%	5.85%
1226000	MARGARETVILLE MEMORI	10.35%	9.38%	10.35%	9.38%
5721000	MARY MC'CLELLAN HOSP	11.82%	10.57%	11.82%	10.57%
0101003	MEMORIAL HOSP. (ALBA	14.17%	12.41%	14.17%	12.41%
1921000	MEMORIAL OF GREENE C	7.41%	6.90%	7.41%	6.90%
1527000	MOSES-LUDINGTON HOSP	37.97%	27.52%	37.97%	27.52%
1701000	NATHAN LITTAUER HOSP	15.13%	13.14%	15.13%	13.14%
1523000	PLACID MEMORIAL HOSP	6.67%	6.25%	6.67%	6.25%
4102002	SAMARITAN H. OF TROY	6.97%	6.51%	6.97%	6.51%
4501000	SARATOGA HOSPITAL	23.28%	18.88%	23.28%	18.88%
4601002	ST CLARES SCHENECTAD	8.00%	7.41%	8.00%	7.41%
4102001	ST MARYS H. OF TROY	17.11%	14.61%	17.11%	14.61%
2801001	ST MARYS OF AMSTERDA	16.80%	14.39%	16.80%	14.39%
0101004	ST PETERS HOSPITAL	10.51%	9.51%	10.51%	9.51%
4601004	SUNNYVIEW HOSP. & RE	4.36%	4.18%	4.36%	4.18%
1227000	THE HOSPITAL	3.59%	3.46%	3.59%	3.46%
	TOTAL NORHTEAST				
3523000	ARDEN HILL HOSPITAL	9.17%	8.40%	9.17%	8.40%
5501000	BENEDICTINE HOSPITAL	14.06%	12.32%	14.06%	12.32%
5957000	BLYTHDALE	3.10%	3.01%	3.10%	3.01%
5902002	BURKE REHABILITATION	6.60%	6.20%	6.60%	6.20%
5263000	COMMUNITY GEN. @ HAR	15.37%	13.32%	15.37%	13.32%
5253000	COMMUNITY GEN. @ HER	4.79%	4.57%	4.79%	4.57%

14-Feb-86

ESTIMATED 1986 CAPITAL AS A PERCENTAGE OF REVENUE

OPCERT	HOSPITAL NAME	TOTAL CAPITAL AS A PERCENT OF OPERATING	TOTAL CAPITAL AS A PERCENT OF TOTAL REVENUE	TOTAL CAPITAL & CONSTRUC. AS A PERCENT OPERATING	TOTAL CAPITAL & CONSTRUC. AS A PERCENT TOTAL REVENUE
3522000	CORNWALL HOSPITAL	11.58%	10.37%	11.58%	10.37%
5925000	DOBBS FERRY HOSPITAL	7.18%	6.70%	7.18%	6.70%
5526001	ELLENVILLE COMMUNITY	5.94%	5.61%	5.94%	5.61%
4329000	GOOD SAMARITAN SUFFN	42.65%	29.90%	42.65%	29.90%
4322000	HELEN HAYES HOSPITAL	21.60%	17.76%	21.60%	17.76%
1301000	HIGHLAND HOSP BEACON	9.40%	8.59%	9.40%	8.59%
3501000	HORTON MEMORIAL HOSP	15.80%	13.64%	15.80%	13.64%
3920000	JULIA L. BUTTERFIELD	6.01%	5.67%	6.01%	5.67%
5501001	KINGSTON HOSPITAL	5.67%	5.36%	13.74%	12.08%
5922000	LAWRENCE HOSPITAL, I	9.77%	8.90%	9.77%	8.90%
3535001	MERCY COMMUNITY HOSP	33.09%	24.86%	ERR	ERR
5903000	MOUNT VERNON HOSPITA	8.68%	7.99%	8.68%	7.99%
5904000	NEW ROCHELLE HOSPITA	16.31%	14.02%	16.31%	14.02%
1327000	NORTHERN DUTCHESS HO	12.28%	10.94%	12.28%	10.94%
5920000	NORTHERN WESTCHESTER	11.95%	10.67%	11.95%	10.67%
5902003	NY HOSP CORNELL	2.63%	2.57%	2.63%	2.57%
4324000	NYACK HOSPITAL	22.93%	18.65%	22.93%	18.65%
5901000	PEEKSKILL HOSPITAL	10.76%	9.72%	10.76%	9.72%
5932000	PHELPS MEMORIAL HOSP	6.61%	6.20%	6.61%	6.20%
3950000	PUTNAM COMMUNITY HOS	11.19%	10.06%	11.19%	10.06%
5954000	ST VINCENTS-WESTCHES	5.73%	5.42%	5.73%	5.42%
5902000	ST. AGNES HOSPITAL	12.47%	11.09%	12.47%	11.09%
3529000	ST. ANTHONY COMMUNIT	14.07%	12.34%	14.07%	12.34%
1302000	ST. FRANCIS(POUGHKEE	25.38%	20.24%	25.38%	20.24%
5907001	ST. JOHN'S RIVERSIDE	13.24%	11.69%	23.29%	18.89%
5907002	ST. JOSEPH'S MEDICAL	17.87%	15.16%	17.87%	15.16%
3502000	ST. LUKE'S OF NEWBUR	11.75%	10.52%	11.75%	10.52%
4353000	SUMMIT PARK-ROCK. IN	8.05%	7.45%	8.05%	7.45%
3536000	TUXEDO MEMORIAL HOSP	3.78%	3.65%	3.78%	3.65%
5906000	UNITED HOSPITAL	12.43%	11.05%	12.43%	11.05%
1302001	VASSAR BROTHERS HOSP	12.11%	10.80%	12.11%	10.80%
5957001	WESTCHESTER COUNTY	16.06%	13.84%	16.06%	13.84%
5902001	WHITE PLAINS HOSPITA	8.32%	7.68%	8.32%	7.68%
5907003	YONKERS GENERAL HOSP	10.02%	9.11%	10.02%	9.11%
	TOTAL HUDSON VALLEY				
7003015	ASTORIA GENERAL HOSP	8.28%	7.65%	8.28%	7.65%
7001026	BAPTIST MEDICAL CENT	3.57%	3.45%	3.57%	3.45%
7004006	BAYLEY SETON HOSPITA	37.66%	27.36%	37.66%	27.36%
7002001	BELLEVUE HOSPITAL CT	7.10%	6.63%	7.10%	6.63%
7002002	BETH ISRAEL MEDICAL	10.73%	9.69%	10.73%	9.69%
7003010	BOOTH MEMORIAL MEDIC	10.93%	9.86%	10.93%	9.86%
7000002	BRONX MUNICIPAL HOSP	3.44%	3.32%	3.44%	3.32%
7000001	BRONX-LEBANON HOSPIT	8.29%	7.65%	8.29%	7.65%
7001002	BROOKDALE HOSP. MED.	4.14%	3.98%	4.14%	3.98%
7001003	BROOKLYN-CALENDONIAN	14.56%	12.71%	19.15%	16.07%
7002003	CABRINI HEALTH CARE	9.55%	8.72%	9.55%	8.72%
7000011	CALVARY HOSPITAL, IN	9.46%	8.64%	9.46%	8.64%
7003008	CATHOLIC MEDICAL CEN	18.64%	15.71%	18.64%	15.71%
7001024	CHURCH CHARITY FOUND	11.45%	10.27%	11.45%	10.27%
7003000	CITY HOSPITAL CENTER	3.73%	3.59%	3.73%	3.59%
7002051	COLER MEMORIAL HOSPI	3.70%	3.57%	3.70%	3.57%
7001008	COMMUNITY HOSP.(BROO	19.03%	15.99%	ERR	ERR
7001009	CONEY ISLAND HOSPITA	3.46%	3.35%	3.46%	3.35%
7003017	DEEPDALE GENERAL HOS	4.89%	4.66%	4.89%	4.66%
7004005	DOCTOR'S HOSP. - STA	3.54%	3.42%	3.54%	3.42%
7002004	DOCTORS HOSPITAL, IN	21.91%	17.97%	21.91%	17.97%
7001039	FLATBUSH GENERAL HOS	2.32%	2.27%	2.32%	2.27%
7003001	FLUSHING HOSPITAL	10.92%	9.84%	10.92%	9.84%
7002050	GOLDWATER MEMORIAL H	3.89%	3.75%	3.89%	3.75%
7003013	H.I.P. HOSPITAL, INC	7.51%	6.98%	7.51%	6.98%
7002009	HARLEM HOSPITAL CENT	3.56%	3.44%	3.56%	3.44%
7002012	HOSP. FOR SPECIAL SU	8.53%	7.86%	8.53%	7.86%
7002098	INSTITUTE OF REHAB.	5.09%	4.84%	5.09%	4.84%
7001046	INTERFAITH	4.94%	4.71%	4.94%	4.71%
7003003	JAMAICA HOSPITAL	4.69%	4.48%	4.69%	4.48%
7002052	JOINT DISEASES NORTH	2.06%	2.02%	2.06%	2.02%
7002011	JOINT DISEASES-ORTHO	16.85%	14.42%	16.85%	14.42%

14-Feb-86

ESTIMATED 1986 CAPITAL AS A PERCENTAGE OF REVENUE

OPCERT	HOSPITAL NAME	TOTAL CAPITAL AS A PERCENT OF OPERATING	TOTAL CAPITAL AS A PERCENT OF TOTAL REVENUE	TOTAL CAPITAL & CONSTRUC. AS A PEPCENT OPERATING	TOTAL CAPITAL & CONSTRUC. AS A PERCENT TOTAL REVENUE
7001016	KINGS COUNTY HOSPITA	3.49%	3.37%	3.49%	3.37%
7001041	KINGS HIGHWAY HOSP.	9.66%	8.81%	9.66%	8.81%
7001033	KINGSBROOK JEWISH ME	6.22%	5.86%	6.22%	5.86%
7002017	LENOX HILL HOSPITAL	7.73%	7.18%	7.73%	7.18%
7000008	LINCOLN MEDICAL & ME	15.45%	13.38%	15.45%	13.38%
7001017	LONG ISLAND COLLEGE	18.48%	15.60%	28.68%	22.29%
7003004	LONG ISLAND JEWISH M	13.35%	11.78%	13.35%	11.78%
7001019	LUTHERAN MEDICAL CEN	14.12%	12.37%	14.12%	12.37%
7001020	MAIMONIDES MEDICAL C	8.31%	7.67%	8.31%	7.67%
7002019	MANHATTAN EYE,EAR&TH	15.70%	13.57%	15.70%	13.57%
7002045	MEDICAL ARTS CENTER	1.46%	1.44%	1.46%	1.44%
7002020	MEMORIAL HOSP. FOR C	4.53%	4.33%	4.53%	4.33%
7001021	METHODIST HOSPITAL	21.47%	17.68%	21.47%	17.68%
7002021	METROPOLITAN HOSPITA	3.76%	3.62%	3.76%	3.62%
7000005	MISERICORDIA HOSPITA	21.50%	17.69%	21.50%	17.69%
7000006	MONTEFIORE HOSPITAL	8.57%	7.89%	18.15%	15.36%
7002024	MOUNT SINAI HOSPITAL	7.94%	7.36%	26.61%	21.02%
7002026	N.Y. EYE & EAR INFIR	3.64%	3.51%	3.64%	3.51%
7002000	N.Y. INFIRMARY - BEE	3.99%	3.84%	3.99%	3.84%
7002029	N.Y. UNIVERSITY MED.	10.65%	9.63%	10.65%	9.63%
7000024	NORTH CENTRAL BRONX	10.16%	9.22%	10.16%	9.22%
7002025	NY HOSP. & PAYNE WHI	16.41%	14.09%	ERR	ERR
7003025	OSTEOPATHIC HOSPITAL	3.78%	3.65%	3.78%	3.65%
7003020	PARKWAY HOSPITAL	4.94%	4.71%	4.94%	4.71%
7003021	PARSONS SANITARIUM,	2.94%	2.85%	2.94%	2.85%
7000019	PELHAM BAY GENERAL H	1.99%	1.95%	1.99%	1.95%
7003006	PENINSULA HOSPITAL C	4.95%	4.72%	4.95%	4.72%
7003022	PHYSICIANS HOSPITAL	1.48%	1.46%	1.48%	1.46%
7002030	PRESBYTERIAN HOSPITA	9.15%	8.38%	29.05%	22.51%
7003007	QUEENS HOSPITAL CENT	3.85%	3.71%	3.85%	3.71%
7004000	RICHMOND MEMORIAL HO	6.93%	6.48%	18.82%	15.84%
7002031	ROCKEFELLER UNIVERSI	1.61%	1.59%	1.61%	1.59%
7000014	ST. BARNABAS HOSPITA	9.50%	8.67%	9.50%	8.67%
7002033	ST. CLARE'S HOSP.& H	2.64%	2.57%	2.64%	2.57%
7002032	ST. LUKE'S-ROOSEVELT	7.31%	6.81%	7.31%	6.81%
7001025	ST. MARY'S OF BROOKL	11.16%	10.04%	11.16%	10.04%
7004001	ST. VINCENT'S (RICHM	8.64%	7.95%	8.64%	7.95%
7002037	ST. VINCENT'S HOSPIT	15.06%	13.09%	19.59%	16.38%
7001037	STATE UNIV. - DOWNST	7.67%	7.13%	7.67%	7.13%
7004003	STATEN ISLAND HOSPIT	14.00%	12.28%	14.00%	12.28%
7000009	UNION HOSPITAL ASSOC	1.46%	1.44%	13.41%	11.82%
7001032	VICTORY MEMORIAL HOS	7.00%	6.54%	22.97%	18.68%
7000023	WESTCHESTER SQUARE H	8.52%	7.85%	8.52%	7.85%
7001045	WOODHULL MED & M. H.	33.55%	25.12%	33.55%	25.12%
7001035	WYCKOFF HEIGHTS HOSP	5.39%	5.11%	5.39%	5.11%
	TOTAL NYC				
5123000	BROOKHAVEN MEMORIAL	5.85%	5.53%	5.85%	5.53%
5120000	BRUNSWICK HOSPITAL C	8.57%	7.89%	8.57%	7.89%
2952002	CENTRAL GENERAL HOSP	5.47%	5.19%	5.47%	5.19%
5155000	CENTRAL SUFFOLK HOSP	19.56%	16.36%	19.56%	16.36%
2901000	COMMUNITY AT GLEN CO	12.42%	11.04%	12.42%	11.04%
5127000	EASTERN LONG ISLAND	10.72%	9.69%	10.72%	9.69%
2910000	FRANKLIN GENERAL HOS	9.88%	8.99%	9.88%	8.99%
5154001	GOOD SAMARITAN-WEST	11.07%	9.97%	11.07%	9.97%
2906000	HEMPSTEAD GENERAL HO	7.43%	6.91%	7.43%	6.91%
5153000	HUNTINGTON HOSP. ASS	9.22%	8.44%	9.22%	8.44%
5149000	JOHN T. MATHER MEMOR	16.44%	14.12%	16.44%	14.12%
2902000	LONG BEACH MEMORIAL	7.76%	7.20%	27.96%	21.85%
2904000	LYDIA E. HALL HOSPIT	7.57%	7.04%	7.57%	7.04%
2950000	MASSAPEQUA GENERAL H	4.92%	4.69%	4.92%	4.69%
2909000	MERCY HOSP. ASSOCIAT	9.72%	8.86%	9.72%	8.86%
2952001	MID-ISLAND HOSPITAL	1.54%	1.52%	1.54%	1.52%
2950002	NASSAU COUNTY MEDICA	10.77%	9.72%	10.77%	9.72%
2908000	NASSAU HOSPITAL ASSO	7.00%	6.55%	7.00%	6.55%
2951001	NORTH SHORE UNIVERSI	10.04%	9.12%	10.04%	9.12%
5157001	SMITHTOWN GENERAL HO	8.30%	7.66%	8.30%	7.66%
2950001	SOUTH NASSAU COMMUNI	11.62%	10.41%	11.62%	10.41%

ESTIMATED 1986 CAPITAL AS A PERCENTAGE OF REVENUE

:RT	HOSPITAL NAME	TOTAL CAPITAL AS A PERCENT OF OPERATING	TOTAL CAPITAL AS A PERCENT OF TOTAL REVENUE	TOTAL CAPITAL & CONSTRUC. AS A PERCENT OPERATING	TOTAL CAPITAL & CONSTRUC. AS A PERCENT TOTAL REVENUE
300	SOUTHAMPTON HOSP. AS	6.99%	6.54%	6.99%	6.54%
000	SOUTHSIDE HOSPITAL	7.45%	6.93%	7.45%	6.93%
001	ST. CHARLES HOSPITAL	5.44%	5.16%	5.44%	5.16%
000	ST. FRANCIS HOSP. (RO	9.35%	8.55%	9.35%	8.55%
001	STATE UNIV. @ STONY	43.00%	30.07%	43.00%	30.07%
	TOTAL NASSAU-SUFFOLK				
	STATEWIDE TOTALS:				
	WESTERN	11.31%	10.16%	11.31%	10.16%
	FINGERLAKES	5.81%	5.49%	5.81%	5.49%
	CENTRAL	8.41%	7.76%	9.21%	8.43%
	NY PENN	9.03%	8.28%	9.03%	8.28%
	NORTHEAST	9.54%	8.71%	9.67%	8.82%
	HUDSON VALLEY	14.22%	12.45%	14.82%	12.90%
	NEW YORK CITY	9.21%	8.44%	12.00%	10.71%
	NASSAU-SUFFOLK	10.55%	9.55%	10.96%	9.88%
	STATEWIDE TOTALS:	9.91%	9.01%	11.73%	10.50%

Senator DURENBERGER. Kathy.

STATEMENT OF KATHLEEN E. MEANS, DIRECTOR, PROGRAM PAYMENT MANAGEMENT, BLUE CROSS & BLUE SHIELD ASSOCIATION, CHICAGO, IL; AND FORMER DIRECTOR, DIVISION OF HEALTH FINANCING POLICY, OFFICE OF ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. MEANS. Thank you, Mr. Chairman. I am happy to be able to testify this morning on behalf of the Blue Cross Association. Of course, as you are aware, I did work on the capital study and managed that study in the last year of its development in HHS, in ASPE.

The association has been on record for more than a year as supporting a capital inclusive DRG pricing system. We think that there are a number of principles, however, that should guide the transition from the current cost passthrough to the capital system.

I think the first important principle is a reasonable transition period. When you consider the role of the transition, I think it is mainly to try to minimize financial disruption to the highly leveraged hospitals at the beginning of the transition. There is a corresponding relationship in that those hospitals that are capitalized well below the national average rate do receive an infusion of additional capital dollars as you move towards the national rate. But we consider that to be of a lesser consequence in considering how the transition should be structured, other than being concerned that hospitals below the average not receive windfall profits.

Second, we are concerned that there be adequate payment levels. This does not relate exclusively to the capital policy but also to the overall adequacy of the PPS payments in general. Particularly as you fold capital in, I think there is considerable concern in the future about the annual increases and updates to the overall PPS rates. Any undue constraint on the operating side will also compress payments for capital. I think that is an important issue.

In that regard, we particularly support the aspects of your proposal that provide for a longer transition; and that provides for a rolling base in terms of the hospital-specific portion that is, calculating hospitals' actual current capital reimbursement levels for the hospital-specific portion.

Finally, we think that it is very important to be able to respond through the system to exceptional circumstances. I think the key issue here is for new hospitals, or as one prior panelist mentioned, it is also possible that a major renovation is so extensive that, in fact, for reimbursement purposes that hospital constitutes a new hospital.

Also, we believe that this reform to Medicare should be implemented through legislation and not through regulation.

Let me make some quick observations based on what I have heard prior panelists make references to, and then just some information, knowledge, that I gleaned by studying the issue when I worked at HHS.

One thing to keep in mind is consideration of what under the system generates savings—for instance, from a deficit-reduction standpoint, savings come from many sources under this proposal. It is possible that there are some savings inherent in shifting to a per-case payment absent any other change in the system, even with a rolling hospital-specific portion base. This is partly due to the effects of relating the capital payment to case mix and partly due to declining occupancy levels.

In response to a question that Senator Baucus raised, when we were studying high capital hospitals, hospitals with capital to operating ratios in excess of 12 percent, the distribution of investment by type of hospital was roughly equal to the way those hospitals are distributed on average nationwide. So there is no particular pattern. Investor-owned hospitals were represented in the same proportion in the high capital group as they are nationwide; same thing for urban-public's and whichever other categories you choose.

One final comment, quickly, on the nature of the capital issue in general. A lot of people have made reference to a capital cycle this morning. I think one important thing to appreciate about that is that for major investments it is true that those tend to be cyclical, but more importantly, they permanently change the underlying expense structure of a particular hospital once it has capitalized that major investment.

The issue then is one of the extent to which or the rapidity with which revenues rise to appropriate levels to come into equilibrium with those expenses.

In this regard, we did some analysis at HHS relating Medicare revenues to Medicare expenses, studying all of the hospitals in the country. Under cost reimbursement it is important to realize that one-third to one-half of the hospitals had revenues less than or equal to Medicare expenses. They received less from Medicare under cost reimbursement than their expenses for a number of reasons: Per case limits, Medicare's definition of allowable costs. When we compared that to per case payments, that relationship improved considerably on average nationwide. A significant number of hospitals generated revenues greater than expenses under the prospective payment system. That was modeling at an average payment level of 6.89 percent for capital.

Finally, just one comment, quickly, on the industry at large. The hospital industry is a very interesting industry to analyze. If you refer back to the data that AHA submitted at the Ways and Means Committee hearing, they indicated, for instance, for 1984 that one-half of the hospitals in the country had negative patient operating margins. I do not think that operating margins per se should be a key factor in your consideration of what an appropriate payment level for capital is.

Many hospitals chronically run deficits, and they run them for significant periods of time. There are various reasons for this, but I do not think that that issue alone should greatly influence your thinking on the appropriate level for capital.

Thank you.

Senator DURENBERGER. Thank you very much.

[The prepared written statement of Ms. Means follows:]

TESTIMONY OF THE
BLUE CROSS AND BLUE SHIELD ASSOCIATION

MEDICARE PAYMENT FOR CAPITAL COSTS

BEFORE THE
SENATE FINANCE COMMITTEE
SUBCOMMITTEE ON HEALTH

PRESENTED BY:

Kathleen Means
Director of Payment Management
Blue Cross and Blue Shield Association
March 14, 1986

Mr. Chairman, Members of the Subcommittee, I am Kathleen Means, Director of Payment Management for the Blue Cross and Blue Shield Association. Thank you for the opportunity to present our views on Medicare hospital capital payment reform. The Association is the national coordinating agency for all of the nation's Blue Cross and Blue Shield Plans.

The deliberation of the Subcommittee on reform of Medicare capital payment policy can have a direct impact for years to come on the hospital industry's ability and capacity to serve not only the Medicare population, but all the people of this country. The Medicare program is such a major source of revenue to hospitals (about 40% on average for inpatient services) that any significant change in payment policy must be considered carefully.

Need for Reform

When the Congress enacted the Medicare prospective payment system it exempted hospital capital-related costs — depreciation, interest, and return on equity capital payments — from the new system and set October 1, 1986 as the deadline for adopting a new capital payment policy. As a result, capital costs continue to be paid on a cost reimbursement "pass-through" basis. In 1983, the Congress also gave notice that capital obligations entered into by hospitals after March 1, 1983 may receive different treatment under the new capital payment policy than earlier obligations.

Hospital investment in capital is a significant and essential element in producing quality health care. Periodic reinvestment is necessary to maintain, renovate and replace facilities, as well as to modify services. It is often necessary to invest in order to improve the efficient operation of a facility. The challenge to payors of health care is to recognize this in payment systems without encouraging or contributing to capacity or services that are not needed and without undermining the capacity to provide needed services.

With respect to the Medicare program, the current mix of prospective payment for operating costs and cost reimbursement for capital expenses creates a number of problems. Most importantly, it creates inappropriate incentives for hospitals to substitute capital for labor or other inputs. If both types of expenses were covered under a prospective payment system, hospital resource allocation decisions regarding plant, equipment, staffing and support functions would be based primarily on the need to improve efficiency and maintain or improve patient care.

In addition, cost reimbursement for hospital capital expenses, without effective limitations, does not promote financial discipline because it insulates hospitals from the negative consequences of poor investment decisions. The current method of determining Medicare cost reimbursement for capital expenses "subsidizes" excess hospital capacity. For example,if a 200 bed hospital is operating at only 50% of full capacity and Medicare patients represent 50% of the total patient load, the Medicare program could pay half of the hospital's capital expenses relating to maintaining its full 200 bed capacity.

These problems have led to proposals by the Administration and Members of Congress to include a factor for capital costs in Medicare prospective payment rates for hospitals.

Principles of Reform

We agree in principle with the development of capital—inclusive DRG pricing. In our view, the advantages of incorporating capital costs as part of the overall DRG price far outweigh the disadvantages. It is consistent with the price-based payment method created under PPS and links payment for capital directly to actual patient volume rather than to the hospital's total capacity which may be excessive. It also eliminates the artificial separation of capital and operating costs reimbursement, thereby promoting more rational decisionmaking by hospitals concerning the allocation of its resources. Finally it creates incentives for hospitals to evaluate carefully proposed capital expenditures and defer projects when the cost of capital is high.

In our view, there are four principles that should guide the development and evaluation of specific reform proposals. They are providing 1) a reasonable transition, 2) an adequate basis for determining average payment levels, 3) an adjustment process for exceptional circumstances, and 4) establishing reform through the legislative process.

First, we believe that a reasonable transition provision should be provided to enable hospitals time to adjust to the new method. Developing transition policy involves consideration of the length of the transition, the rate at which the new capital payment system is phased in, and the basis for calculating payment amounts.

A reasonable transition period is essential to the financial stability of hospitals that are highly leveraged with respect to capital expense at the time the transition period begins. Such hospitals individually could abruptly lose millions of dollars in otherwise anticipated Medicare payments. The transition period provides hospitals the opportunity to adjust operating and financial plans to assure a balance between revenues and expenses. This is essential if hospitals are to be able to meet the expenses of already incurred fixed capital expenditures.

On the other hand, those hospitals that have capital expenses below the national average, including many public hospitals, will benefit from a shift to DRG-based capital payments. While this may be viewed as a positive consequence of the proposed policy, we do not believe the additional infusion of dollars should be at windfall levels. A longer transition period still infuses additional Medicare revenues into those hospitals, but at a more moderate pace than does a short transition.

The rate at which the new payment system is phased in is also an important consideration. To assure a smooth transition, we believe that the hospital-specific portion of the rate should be heavily weighted in the earlier years of the transition. To make this portion of the rate truly hospital-specific, we believe that the hospital's actual capital costs during each year of the transition should be used as the basis for determining the payment rate. This could be accomplished by estimating for the hospital-specific portion of the payment each hospital's capital costs at the beginning of the rate year and then adjusting that amount after receipt of the Medicare cost report.

The second recommended principle of reform relates to the national average level at which prospective payments for hospital capital will be set. We believe that Medicare payments for capital should be adequate to recognize the costs that hospitals must incur in providing needed services to beneficiaries and should reasonably reflect overall trends in market conditions. We caution against viewing revising payment to hospitals for capital primarily as an opportunity to achieve budget savings. The basic design of the system could reduce aggregate Medicare payments for capital absent a requirement for budget neutrality. Changes in Medicare's payment policies for hospitals' capital expenditures carry far-reaching implications for the cost and availability of health care services in the United States. Therefore we urge careful consideration before proceeding with further reductions to the cost base used to establish national average payment levels.

Third, because a national Medicare payment system cannot be as sensitive to unique and local circumstances as may be appropriate, we believe a mechanism should be established to authorize adjustments to capital payments where this is clearly demonstrated to be necessary for the continued viability of needed facilities. Related to this is the need to establish a data gathering and monitoring system that can track the effects of the new payment system on the hospital industry including its effect on capital formation. Adjustments to the DRG weights or to the average payment levels to reflect new technology, availability of financing, and the aging of facilities are among the important capital-related issues that need to be monitored and addressed in the future. This can be done only with a serious commitment to the monitoring and evaluation process.

Fourth, we believe as a matter of principle that revising Medicare payment policies for capital should be the subject of broad public debate and should be considered as part of the legislative process rather than as a regulatory matter. The legislative process would in our view provide ample opportunity for public input and a more reasonable time period to assess the potential effects of various reform proposals on the nation's hospitals.

The Administration's Proposal

Under the Administration's proposal, a set amount for capital would be added on to PPS rates. According to recent Congressional testimony by the Department of Health & Human Services, the amount for capital would be a blend between the national average amount per DRG and a hospital-based component based on historical costs updated by a trend factor. Over a four-year transition period, the capital add-on increasingly would be based more on the national average and less on the hospital-specific factor.

We question whether the Administration's proposed payment method will, in practice, fairly compensate health care institutions' capital costs. Critical in this regard are the formula used to calculate the average payment amounts and the length of time and manner of transition for implementation of the new capital payment method.

It is important to understand that shifting to a per case payment unit for capital redistributes the pool of Medicare dollars differently across hospitals than does the cost reimbursement formula. The length and blending proportions of the transition should be designed to assure that this redistribution occurs gradually. The Administration's proposal could jeopardize many hospitals' financial security by placing too little emphasis on hospital-specific costs during the transition and by providing too little time to allow hospitals to adjust to the new payment system.

For example, the hospital-based payments would not be truly hospital-specific since the Administration plans to use a fixed base of FY 1983 capital payments to determine each facility's hospital-based payment. Also, the hospital-based amount declines very rapidly as a proportion of the total capital payment over the four year transition. Another example of a too abrupt transition relates to the way in which return on equity and interest on funded depreciation are treated for purposes of the hospital-based payments. Payment for these elements would be phased out of the hospital-based portion of the rate over a three year, rather than a four year period. While we agree that payment for return on equity and interest offset need not be continued under the prospective payment system, we question whether payments for these factors should be reduced as abruptly as the Administration proposes.

Senator Durenberger's Proposal

Senator Durenberger's proposal, S. 2121, differs from the Administration's proposal in three major respects. First, it provides a 7 rather than a 4 year transition period. Second, it bases the hospital-specific portion of Medicare's capital payment for each year of the transition on the hospital's actual capital costs for that year. Third, the hospital-specific portion of the blended rate is weighted more heavily in the early years of the transition, thus providing some protection to highly leveraged hospitals.

While we believe there are many acceptable ways of providing a more current hospital-specific payment amount and a more gradual transition period, we are encouraged by Senator Durenberger's approach. We look forward to providing the Senator detailed comments on his proposal after we have had an opportunity to review it more thoroughly.

Conclusion

We are pleased that the Congress and the Administration are devoting considerable efforts this year to the reform of Medicare capital payment policies. The failure to agree on a specific proposal this year will only postpone the introduction of needed reform, and will further increase the uncertainty under which hospitals must make investment decisions that are critical to the future of the health care delivery system. We fully support the principle of incorporating a capital element into Medicare prospective payment rates and look forward to assisting the Subcommittee in any way we can as you proceed in this very important but highly complex area.

Senator DURENBERGER. Let me be brief and submit this long variety of questions that we have for each of you for the record.

But let me ask one question which deals with outliers at both ends, I suppose, for those of you who want to respond to it. I did not expect the previous panel to indicate that there were any windfalls for any hosoitals in the system. But we all know there are. If we are going to try to average anything in this process, there are at some point in time windfalls for a certain set of hospitals.

On the other end, Dr. Schwartz and others who represent those who are penalized by an effort to do some kind of averaging in transition. It has been suggested that we have an exceptions process of some kind for those at Schwartz's end of the scale. I am not sure because I have not read all the testimony whether there have been any recommendations about how to pick up some savings at the other end from those who will be the beneficiaries of a windfall in the capital transition. Does anybody have any thoughts on either of those subjects? Ron?

Mr. KOVENER. Unfortunately, the institutions people at the low end are probably the ones that will need more capital in the relatively near future. The opportunity for them to accumulate of capital through a payment rate that is higher than their immediate need is not going to meet the real need of the institution. So, unfortunately, I do not see a low end outlier. I only see the problem of the high end outlier resulting from the already existing commitments that just cannot be avoided as a result of the new payment system.

Senator DURENBERGER. Ed.

Mr. SCHWARTZ. Mr. Chairman, I think it is important to note that the low-end outliers we are talking about in many cases are people who have 100 percent depreciated facilities. They receive payment once under the Medicare system. And this savings that we refer to here gives them the ability to collect part of that twice.

I do not have a specific proposal on the low end. I would say that our figures indicate that if we took the pool—and our testimony did not go into it here but it indicates we favor a percentage add-on rather than a flat rate increment to each DRG. If you took one-tenth of 1 percent of that amount and set it aside for managing an exception process for outliers, our figures indicate that on a national level would be adequate to address that problem.

As a high-end outlier, I would only want to comment to you that we have already said in other testimony that it is the age of the facilities that creates a part of the problem. And ours, indeed, are over 35 years old. But it is also the cost of money. As you see these figures going off the top of the chart, it relates to what the interest rates have done during projects. And it is also because the Medicare has been depreciating the old buildings on historic costs rather than replacement. And so when you have an institution like ours, it waits 50 years to replace its main building, we apologize, but we cannot do it for what we could have done it 50 years ago. And that is a significant difference in the way they are keeping score on capital investment.

Mr. MIDDLETON. Senator, I would concur with the gentleman from Minnesota as far as the high-ended outlier is concerned because the University of Virginia Medical School is in exactly the same position. And I am here speaking for teaching hospitals today.

But to the extent that there are a number of low-ended outliers out there that have funded depreciation that is grossly inadequate for replacement, that has got to be addressed somehow or another because those facilities who funded their appreciation based upon accepting accounting principles and got it funded and now they have to replace the funded depreciation generally, is woefully short of the capital it is going to take to replace it.

Senator **Durenberger**. Any other comments? Kathy?

Ms. **Means**. A couple of comments. I think this gets to the basic concept of folding capital into the PPS rate. And I think the underlying principle of that in the long term is that the payment system should not distinguish between whether hospitals are spending on the operating side or on the capital side.

It is true that some hospitals, like a lot of the major urban public hospitals, will eventually receive an additional infusion of dollars. It is correct that, in fact, those are already in addition to assets that are depreciated and for which they already received Medicare reimbursement. But aside from that comment, those hospitals are not necessarily likely to use this additional money for capital investment. But I do not think that is a decision in which Federal Government ought to be involved in any way or should you give it undue consideration in your own deliberations.

The deficit analysis that we had done in the Department strongly suggested that those hospitals will simply use that additional money to subsidize operating deficits. Whether an individual facility in fact does that or starts to try to accumulate those funds for capital investment, I do not think is a primary issue here. I think that should be left up to the hospital managers.

We did examine outlier approaches in HHS, as Bob Helms indicated. And I am certain that they could provide more detailed information to you, but I think there are two or three options available to you to consider. How you rank them in terms of preference depends on your own views about how regulatory they are. And as one of the other panelists commented, how "idiot-proof" they might be.

I think the most obvious thing is that for the course of a transition period or permanently for new hospitals, you could exempt them from the PPS average rate for a period of time, a stipulated period of time, say, 3 years or 5 years, and continue to pay them on cost reimbursement. Or you could alternatively do a blend, temporary blend, for three years or five years or whatever your benchmark would be for the hospital-specific portion of the average rate similar to the system in place for sole-community hospitals. A similar methodology could be adopted just for new hospitals or major renovated hospitals.

And we also looked at an outlyer policy that was comparable to the existing outlyer policy for long stay or extremely expensive cases. That is a much problematic approach to try to adopt. It is possible to carve out an outlyer fund for high capital hospitals and pay additional amounts to them through the course of the transition. However, you would almost surely need to establish a number of screens, qualifying criteria, by which to judge those hospitals' need for such outlyer payment. There are some choices. They all require a certain amount of information reporting. You could either develop a composite asset age analysis for those hospitals, an index value; you could look at capital of operating ratios, although you should do that with caution because a low operating cost hospital could look as though it is high capital when it is not. You could look at the debt/equity ratios.

Senator **Durenberger**. Yes.

Mr. Abernethy.

Mr. **Abernethy**. If you are going to create an outlyer policy and not give away the store, you have to have decisionmakers. I am sure you can anticipate what my response to who that ought to be. I do believe the problem you are facing here is that you are trying to manage a complicated system and do it simply.

One option that was addressed by Senator Bradley earlier is to allow the States who wish to do so to have a decisionmaking role with respect to who gets more and who gets less. And certainly a final option is to not have a transition as it has been structured by the administration, but to simply announce that you are going to go to an add on at some point in the future and to use, subject to some form of capital investment limits, a capital decisionmaking process at the State and local level until you get to that point. That, at least, has the benefit of, as I said, not giving away the store; that is, increasing total capital investment in the system, which I think every proposal that I have heard today or at the similar hearing before the Ways and Means Committee. You are being asked basically to provide substantially more money in the system. That is the outcome of the various transition proposals.

Senator **Durenberger**. Thank you all. I need to ask all of you to respond in writing to the old capital-new capital question and to the fixed versus moveable or fixed versus equipment; should we make those distinctions as recommended by PRO PAC and others. So you will be sure to respond to those in addition to more detailed specific questions we give you.

I will let you go. Thank you all very much for your testimony.

Senator **Durenberger**. Our final panel is Michael J. Kalison and Richard Averill, Health Systems International; Dr. Gerard Anderson, associate director, the Center for Hospital Finance and Management, Johns Hopkins; Dr. Hugh W. Long, associate professor of Corporate Finance and Health Systems Management, Tulane.

Gentlemen, we welcome you and your testimony. Your submitted testimony will be made part of the record, and you may proceed to summarize that beginning with Mr. Kalison.

STATEMENT OF MICHAEL J. KALISON, MANAGER, KALISON, MURPHY & McBRIDE, MORRISTOWN, NJ, ACCOMPANIED BY RICHARD AVERILL, VICE CHAIRMAN, HEALTH SYSTEMS INTERNATIONAL, NEW HAVEN, CT

Mr. **Kalison**. Thank you, Senator. Thank you for inviting myself and Richard Averill to appear before you this morning. We were both involved in the development of the first DRG payment system in New Jersey in the late 1970's. And although we are both in the private sector now, we have maintained our system in this policy.

As many have observed this morning, the success of PPS does suggest that the hospital industry responds to financial incentives. As you noted a few minutes earlier, in 1983 prospective payment by the case was applied to over 90 percent of the cost to deliver inpatient services. That is labor and supplies. Overall utilization went down, and with it the rate of inflation. And I believe that the decision to leave capital out of the rate at that point in time made sense insofar as it provided some security as the industry advanced into an unknown financial environment.

But leaving capital in the rate has had its price, unfortunately. In New Jersey where prospective payment by DRG was first implemented with a capital pass-through, there has been a surge in capital spending at the same time that occupancy has declined from 90 percent to under 70 percent. From 1979, the year the New Jersey system was enacted, through 1981, the New Jersey health care planning system approved over $1.5 billion in capital spending, within all but three States on a per capita basis. Capital reimbursement to New Jersey hospitals increased more than 20 percent between 1983 and 1984 alone.

As you might expect, a moratorium on capital spending was imposed. And as the Commissioner of Health noted in a recent memorandum, and I quote: "An unintended incentive for hospitals has been created to increase and maximize capital spending." I am sure you will understand if I do not concur entirely with Mr. Abernethy's remarks about the effectiveness of health planning.

We think that the time has come to include capital in prospectively determined rates per case. Removing the artificial distinction between capital and noncapital inputs will make the rate structure more internally consistent, thereby encouraging hospital managers to consider the full range of operational tradeoffs.

Our testimony discusses the undesirable incentives which your proposal reverses, and I will not bore you with it. However, I would like to add this: Linking capital to real volume will create the conditions leading to the closure of unneeded and inefficient facilities. This is a very important result in a time when we are operating under an environment of scarce resources. And, again, disagreeing a little bit with Dr. Abernethy, it will also, in my opinion, naturally diminish the need for health planning which, as the New Jersey experience suggests, has not been totally effective.

However, we do think that capital should be added to the rates as accurately and as fairly as possible, and that is our main point—more specifically, on a DRG-specific basis. In private industry where this idea has its roots, this is called "cost base pricing." It is, in fact, the standard way of doing business.

For example, an automobile manufacturer produces both compact cars and station wagons. Since it is not unlikely that different kinds of amounts of inputs—labor, supplies and capital—will be required to produce station wagons as opposed to compact, industry applies standard cost accounting techniques to determine the respective prices of each. Or to put it another way, without first accurately establishing the cost to produce a given product, it is simply not possible to determine whether or not one is earning a profit.

With respect to PPS, I would characterize cost base pricing for capital as the fine-tuning adjustment which creates equilibrium.

For example, using data from HCFA in which capital costs represents 6.8 percent of total costs and examining the percentage of capital cost by DRG, we find the following kinds of variations: Patients admitted to have a simple change of pacemaker battery—that is, DRG 118—would require a capital component of about 4.1 percent. On the other hand, patients admitted for multiple trauma with significant complications—DRG 444—would require a capital component of 8.2 percent or roughly double the percentage. You can see how major trauma centers might suffer if the capital component were simply a flat add-on of 6.8 percent.

So we would like to see DRG-specific methodology spelled out in your legislation in contrast to the flat capital add-on applied to the DRG rates which are currently computed for operating costs. Minimally, however, we think that the proposal should contain language directing the Secretary to incorporate capital on a DRG-specific basis.

In conclusion, we noted that in our testimony that your bill is generally viewed as fair. We also noted that there are certain areas that might merit further attention. We agree in substantial part with some of the comments made by Mr. Owen and Mr. Bromberg concerning the period of transition.

And, finally, we do believe that the capital inflation factor should be spelled out more specifically to avoid the kind of conflict that we see today over the application of the inflation factor generally. But most importantly, we think that the compromises should be reached expeditiously on these matters and that transition should be commenced because, as the New Jersey experience illustrates, the continuing conflict of financial incentives is not harmless.

Senator DURENBERGER. Thank you.

[The prepared written statement of Mr. Kalison follows:]

TESTIMONY OF MICHAEL J. KALISON, ESQ.
MANGER, KALISON, MURPHY & McBRIDE

and

RICHARD F. AVERILL, VICE CHAIRMAN
HEALTH SYSTEMS INTERNATIONAL

BEFORE THE SENATE COMMITTEE ON FINANCE
SUBCOMMITTEE ON HEALTH

Re: THE FAIR DEAL CAPITAL PAYMENT ACT OF 1986

March 14, 1986

INTRODUCTION

The Fair Deal Capital Payment Act of 1986 represents an important step in the evolution of the Medicare Prospective Payment System (PPS). Reversing the traditional method by which Medicare reimburses hospitals for capital expenditures, the "cost pass-through", the practical effect of this proposed legislation is to bring payment for capital into harmony with the way in which Medicare currently pays for virtually all other costs to deliver inpatient services. That is, payments for labor and supplies, which constitute over 90% of the cost to deliver inpatient care (excluding medical education), are currently made prospectively, by the patient case (DRG). Including all costs in the final price of a product is, of course, normal business practice in private industry. Including the costs of capital in the rate per case, called for in the proposed legislation, will eliminate a significant internal inconsistency in the PPS rate design, thereby strengthening the natural incentives of prospective payment. If properly "fine tuned" through the refinement of DRG-specific capital cost allocation, the proposal will also provide for a fairer and more appropriate allocation of scarce resources, thereby leading to greater medical specialization. The overall result should be both higher quality of patient care, as well as improved productivity of the health care system, as a whole.

Context

In contrast to the common practice in private industry and most regulated industries, Medicare reimbursed to hospitals the cost to treat patients until four years ago. With the passage of the Tax Equity and

Fiscal Responsibility Act (TEFRA) in 1982, and PPS a year later, Congress fully reversed this policy with two key exceptions - capital reimbursement and medical education. The reluctance to make all costs fully prospective during the initial period of change was understandable. For example, in New Jersey where DRGs were first used for prospective payment purposes, capital costs (except for major moveable equipment) continue to be passed through, along with other "indirect costs" such as administration and maintenance. Analogous to the Medicare situation three years later, organizing payment by the patient case was viewed as a radical change when it was first proposed in New Jersey in 1979. Justifiably cautious concerning the unknown, the decision was made in both cases to hold certain reimbursement elements constant until more experience could be gained with prospective payment. Nevertheless, the shape of the future was evident in the direction which Congress gave to the Secretary of Health and Human Services (HHS) to propose a method for including capital related costs within amounts prospectively determined for each DRG, by October, 1984.

The problems associated with cost-based reimbursement, as well as the success of prospective payment, are well known. As in other sectors of our economy, hospital managers respond to financial incentives. During the era when providers were reimbursed whatever they spent, managers were encouraged to spend more. In contrast, establishing rates of payment which are "fixed in advance" has furnished hospital managers with incentives to behave more efficiently. By prudently organizing inputs such as labor and supplies, managers increase the margin between revenue and cost, thereby improving the financial health of their institutions. It follows, however, that continuing the cost pass-through policy as applied to capital contradicts the economic incentives which would otherwise apply were capital costs included within the prospective payment framework: More specifically, there are no incentives for hospital managers to minimize the overall cost of new capital investments by selecting the most economically appropriate financial mix, by considering market timing, or by controlling the underlying cost of the project, itself. Indeed, a perverse incentive is created under PPS to substitute capital for labor, whether or not appropriate. Finally, from a quality point of view, there is no rate mechanism to assure the proper allocation of capital based on the needs of varying patient case-mix.

The economic impact of continuing to treat capital in a manner inconsistent with other inputs is not harmless: For example, the New Jersey prospective payment system, with its capital pass-through, was proposed and enacted into law in 1979. In 1984, a report issued by the Governor's Advisory Committee on Capital Expenditures for Health Care Facilities ("Governor's Advisory Committee"), pointed out that between 1979 and 1981, while prospective payment was beginning to exert pressure on non-capital expenditures, the N.J. health care planning system approved $1.5 billion in capital expenditures - on a per capita basis, more than all but three states. The report goes on to point out:

> All these expenditures contribute to higher costs for patients. Because much of the capital investment during the past several years has been debt-financed, we only now are beginning to see these costs reflected in hospital rates. Capital reimbursement to hospitals increased more than 20 percent between 1983 and 1984 alone. Projections for the next two years show increases of between 10 percent and 20 percent a year (under existing reimbursement rules). Moreover, there are over 400 million dollars worth of approved projects waiting to be financed in order for construction to begin. If all of these projects were completed by 1987, the rate of increase between 1983 and 1987 would be approximately 70 percent, or 17.5 percent per year, without any new approvals.[1]

The surge in capital spending in New Jersey furnishes a particularly disturbing example of the power of perverse financial incentives: Since the implementation of prospective payment for operating costs in 1980, the system has gone from under-capacity to over-capacity - a decline in occupancy of approximately 20%. Indeed, in a memorandum issued by Commissioner J. Richard Goldstein on February 11, 1986, the Department of Health estimates that excess capacity statewide may range between 5,000 and 9,000 beds out of 28,000 existing beds, by 1990.[2] These conditions notwithstanding, the memorandum goes on the point out that "[c]oncurrently, in 1986 we are faced with a new wave of proposed capital projects which may exceed $600 million in total construction costs," noting further that because of the capital pass-through, "...an unintended incentive for hospitals has been created to increase and maximize capital spending." Not unexpectedly, New Jersey has imposed a moratorium on new capital expenditures. In a nutshell, the experience in New Jersey suggests that the failure to include capital in the prospective payment framework can produce potentially unnecessary capital investment of a significant level, in spite of declining utilization resulting from prospective payment for operating costs, comprehensive centralized planning, and so forth. Among other things, the Governor's Advisory Committee recommended in the area of reimbursement reform:

> "that all (hospital) capital expenses be reimbursed through a prospective payment system. After a transition period, hospitals (would) receive a fixed price for each DRG which will include a component for capital. The capital component should cover all of the hospital's capital costs, including debt service and depreciation."[3]

Prospective Capital Payment

Removing the artificial distinction between capital and non-capital inputs will make the rate structure more internally consistent, thereby encouraging hospital managers to consider the full range of potential operational trade-offs. Incorporating a capital component into prospectively determined rates will also give hospitals the incentive to make capital investment decisions which are more sensitive to real market conditions, for example: deferring new construction when interest rates are high; substituting more cost effective alternatives such as modernization, or; eliminating unneeded projects altogether. Perhaps most important, linking capital to real volume creates the financial pre-conditions to eliminate unneeded or inefficient facilities. Within a financial environment marked by "scarce resources", devoting capital resources to unneeded or inefficient facilities can only compromise the financial health of the facilities which are needed and efficient. Conversely, promoting the financial health of needed and efficient facilities will occur naturally under a prospective capital payment system sensitive to both volume and patient case-mix.

DRG-Specific Prospective Capital Payments

There are various methods for adding capital to prospectively determined rates, including a fixed amount or fixed percentage add-on. However, private industry has long relied on a more fundamental set of financial principles, generally known as "cost-based pricing", which is designed to more accurately identify the cost of different product lines.[4] The need for this extra sensitivity can be illustrated as follows: An automobile manufacturer produces compact cars and stationwagons. Since it is not unlikely that different kinds and amounts of inputs (including labor, supplies and capital) will be required to produce stationwagons vs. compacts, standard accounting techniques are applied to determine the respective costs of each. To put it another way, without first establishing the cost to produce a given product, it is impossible to determine whether or not a profit is being made on a given line of business. Thus, the principle of "cost based pricing" is nothing new or radical. Rather, it is the standard way for determining financial baselines in private industry. Indeed, it is also the touchstone for determining rates charged by regulated industries, such as electric utilities, to various classes of customers. In the health care industry, it should be no different.

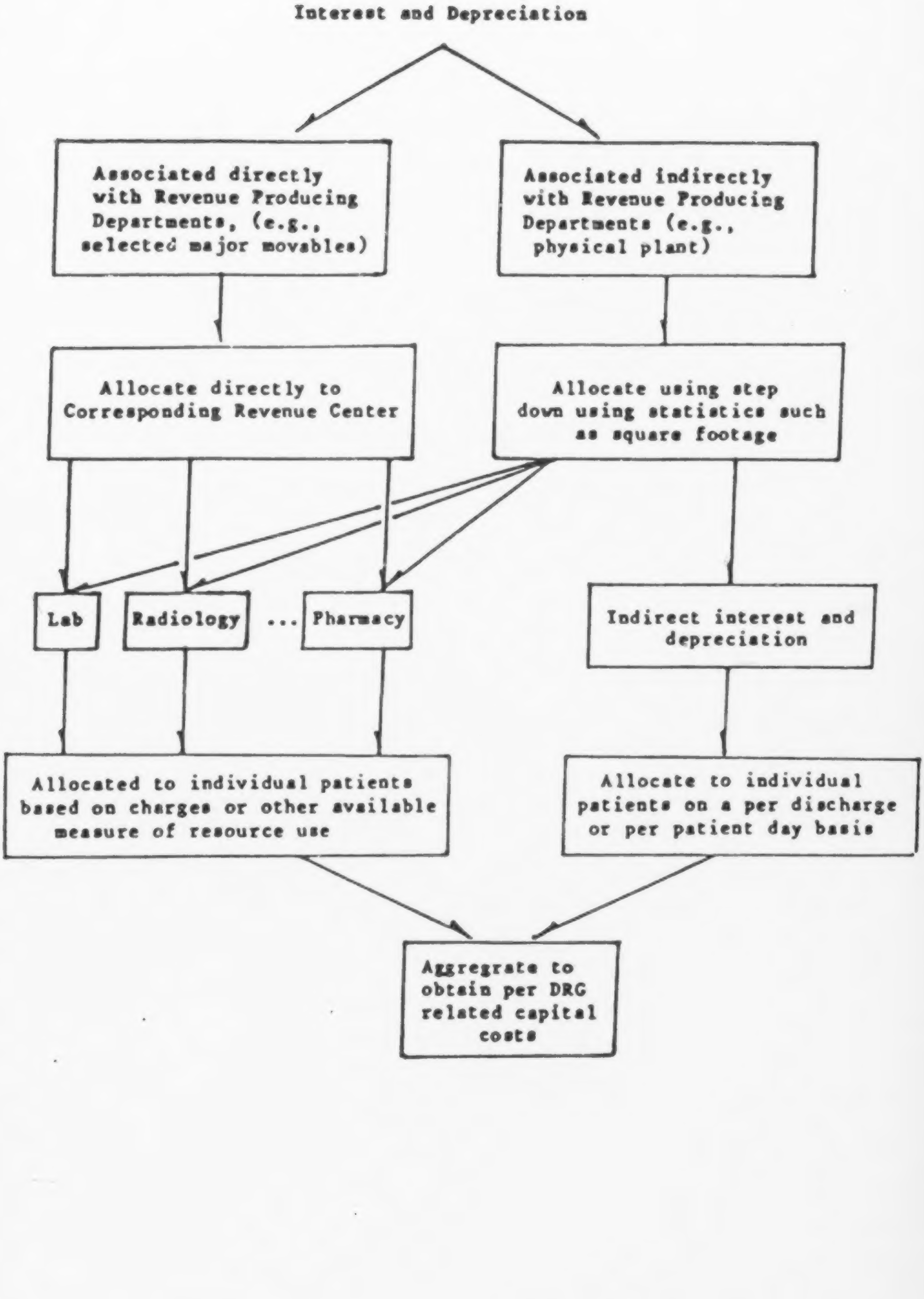
The net effect of adding a fixed percentage to each DRG would be to increase every hospital's total DRG payments by the selected percentage. However, much like the analogy to the manufacturer who produces different kinds of cars, a patient undergoing coronary bypass surgery cannot be expected to require the same kinds and amounts of resources (including capital resources) as a patient facing an uncomplicated appendectomy. A refinement of the DRG add-on approach would treat capital on a DRG specific basis (cost based pricing), which would return to the hospital the appropriate amount of capital for each kind of case it treats. As a result, the total DRG payment for each hospital would be increased by different amounts depending on each facility's case mix. The benefit of this approach is that it recognizes hospitals have different overall capital requirements because of case-mix variations. To put it another way, the failure to incorporate this "fine-tuning" adjustment would lead ultimately to a significant misallocation of resources: Over time, the hospital with a high proportion of "appendectomies" would enjoy a windfall, while the hospital treating a case-mix with more significant capital demands would suffer financial harm. This is an unfair result.

Cost Based DRG Pricing for Capital

The method for determining DRG specific capital factors is straightforward: For each revenue center, such as radiology, laboratory and so forth, a statistic such as charges can be identified that measures an individual patient's relative use of a particular hospital department. This statistic then can be used to allocate the capital expenses for each department (mostly equipment) to individual patients.

The residual indirect capital expenses (mostly plant related) can be allocated to individual patients on a per patient day basis. Once the capital expenses have been completely allocated to individual patients, they can then be aggregated to each DRG. The result is the capital expense associated with each DRG. (See diagram A). For example, a DRG that, on average, consumed twice as many ancillary services and twice as many bed days would receive approximately twice as much payment for capital. Thus, a national set of capital factors would be developed in addition to the cost weights currently associated with each DRG.

The cost accounting approach described above is virtually identical to that used by private industry to allocate cost among various product lines, and by regulated industries to allocate costs among classes of customers. Perhaps more important, the essence of this proposal is to treat capital in the same manner as non-capital expenses, such as nursing services, are currently treated under PPS. A direct relationship between capital and non-capital expenses would be created on a DRG-specific basis. This approach is also consistent with the legislative intent of TEFRA to expand, clarify and unify the methodology for paying for medical services under Medicare Part A. That means finding a way to make a single payment for the entire bundle of non-physician services required to care for a particular kind of case. If proper allocation procedures are followed, incorporating capital costs within DRGs will encourage administrative simplicity, while strengthening the incentives of prospective payment, and contributing to


Interest and Depreciation
Associated directly with Revenue Producing Departments, (e.g., selected major movables)
Associated indirectly with Revenue Producing Departments (e.g., physical plant)
Allocate directly to Corresponding Revenue Center
Allocate using step down using statistics such as square footage
Lab
Radiology
...
Pharmacy
Indirect interest and depreciation
Allocated to individual patients based on charges or other available measure of resource use
Allocate to individual patients on a per discharge or per patient day basis
Aggregrate to obtain per DRG related capital costs

the development of sound national standards. Also, adopting such a system would favorably influence strategic planning insofar as changes in case-mix, which might significantly affect both revenue and cost, would be properly accounted for.

Cost-based pricing will send an important message to providers at the decision-making level. Thus, assuming that capital costs are properly allocated, the correct amount of capital will be returned to each provider, given its own case-mix. As providers study the various components which make up each DRG rate, they can be expected to respond to the demands of real volume and case-mix. Thus, a successful service which the public demands will generate the amount of capital resources necessary to replicate that service, over time; while an unsuccessful service will be naturally terminated. Since quality tends to vary with volume, the increased specialization promoted by more precise cost allocation should result in improved patient care. Although exceptions will always be required to deal with situations such as "sole community provider", where market forces are unable to produce the desired result, in the general environment prospective capital payment will reward hospital management which prudently manages capital resources. The "fine-tuning" adjustment which will promote equilibrium over time by accurately allocating capital resources is DRG-specific prospective capital payment. In the end, it will increase sensitivity to real demand, encourage hospitals to specialize in whatever they do best, and sensitize management to the same kinds of market considerations which the rest of American industry has always been obliged to respect.

A Reduced Role for Planning

The Report of the Governor's Advisory Committee observed:

> The combined effect of required planning review and "pass-through" capital reimbursement is to skew the hospital administrator's responsibility in the capital planning process. Ideally, the administrator would focus on the impact of any capital expenditure on the future viability of the institution. The existing system relieves the administrator of this responsibility. It is left to the regulatory body, acting with imperfect information and under the weight of many applications (and the accompanying pressures), to substitute its judgment for that of hospital management.[5]

Planning was developed as a "gatekeeping" mechanism in a financial environment where providers were reimbursed cost. Apart from the fact that it has failed to evolve a strategy which effectively complements the natural incentives of prospective payment, the current certificate of need process too often diverts hospital management from a fundamental task: the realistic evaluation of proposed investments on a profit and loss basis. By strengthening the risk/reward framework for hospital management, the Fair Deal Capital Payment Act of 1986 will also present planning agencies with an opportunity to assume a diminished, but more focused and effective role. Once the proposal is enacted, studying this opportunity should be the next task of this committee in the area of health care delivery.

The Fair Deal Capital Payment Act of 1986

The draft Statement to the proposed legislation indicates that "[t]his payment will be sensitive to the case-mix and Medicare admissions experienced by hospitals." Although there are cost accounting methods available to HHS which would produce a result equivalent to the approach discussed in this testimony, we would nevertheless much prefer to see the details of DRG-specific cost allocation spelled out in the proposed legislation. Minimally, however, language should be added which instructs the Secretary to compute the DRG weighting factor such that it accurately reflects both the operating costs and the capital costs associated with each individual DRG - i.e., DRG-specific total cost allocation. Also, it is our understanding that the specific provisions set forth in the proposed legislation concerning transition, interest expense, return on equity, local construction costs, changes in capital since the base year and inflation represent a set of compromises which are generally viewed as fair by the hospital community. Although we might have differing views regarding discrete elements of the proposal, we feel that the compromise set forth in this package should not be disturbed. Rather, it is more important to eliminate the artificial distinction between capital and non-capital resources, and to start the process of allocating capital resources more fairly and efficiently. Accordingly, we lend our support to the Fair Deal Capital Payment Act of 1986.

1. GOVERNOR'S ADVISORY COMMITTEE ON CAPITAL EXPENDITURES FOR HEALTH CARE FACILITIES, MAKING LESS DO MORE - CAPITAL POLICY FOR NEW JERSEY HOSPITALS 13 (1984).

2. Memorandum from Commissioner of Health J. Richard Goldstein, M.D. to New Jersey Health Care Administration Board (February 11, 1986) (discussing Capital Policy Proposals).

3. GOVERNOR'S ADVISORY COMMITTEE, MAKING LESS DO MORE, *supra* note 1, at 19.

4. *See generally* Kalison and Averill, *Building Capital into Prospective Payment*, June, 1985 BUSINESS AND HEALTH 34; M. KALISON & R. AVERILL, REGULATION VS. CONTRACT: THE FUTURE OF CAPITAL UNDER PPS (1984).

5. GOVERNOR'S ADVISORY COMMITTEE, MAKING LESS DO MORE, *supra* note 1, at 17.

Senator **Durenberger**. Before we go to the other two witnesses, we are going to have to recess the hearing so I can go over and vote. I am sorry to inconvenience you, and I hope to be back in 10 minutes.

[Whereupon, at 12:08 p.m., the hearing was recessed.]

AFTER RECESS

Senator **Durenberger**. The hearing will come back to order. And I think it is Dr. Anderson next.

STATEMENT OF DR. GERARD F. ANDERSON, ASSOCIATE DIRECTOR, THE CENTER FOR HOSPITAL FINANCE AND MANAGEMENT; AND ASSOCIATE PROFESSOR, HEALTH FINANCE AND MANAGEMENT, THE JOHNS HOPKINS MEDICAL INSTITUTIONS, BALTIMORE, MD

Dr. **Anderson**. Mr. Chairman, my name is Dr. Gerard Anderson, and I am an associate professor at Johns Hopkins University.

I believe the prospective payment for capital is a necessary addition to the Medicare prospective payment system, and that legislation similar to what you propose is necessary to encourage hospitals to remain efficient and to become prudent purchasers.

In my testimony I would like to cover three topics—why prospective payment is necessary; a comparison of the various proposals; and some additional provisions which should be considered. I will try not to repeat the testimony which has been given earlier.

Analysis of the long-term trend in the ratio of capital to operating costs shows that the ratios remain constant at about 7 percent from the period 1970 through 1982. But during 1983 and 1984, the percentages began to increase, and a preliminary indication suggests that there was a substantial increase during 1985. This suggests that hospitals are making capital purchasing decisions to maximize their Medicare payments by combining payments for capital and operating costs. This problem would be eliminated in the proposed legislation since hospitals will not have a financial incentive to over invest in capital.

A related advantage of incorporating capital into PPS is that payment levels would be linked to what the hospital produces and not how the production is generated. Hospitals will no longer have an incentive to produce what economists have called "conspicuous production."

A comparison of the various proposals suggests that there are three dimensions whioh we should take a look at. First of all, the level of aggregate expenditures on capital; second, the method for allocating to individual hospitals; and, third, the phase-in methodology.

I support your proposal which links the aggregate level of capital expenditures to expenditures in some base period trended for inflation. As Bob Helms suggested, most empirical studies trying to define capital needs will require a variety of empirical assumptions and lead to very differing estimates in needs.

However, one potential problem with your proposal and the administration's proposal is the inflation adjustment methodology. The capital component of the hospital market basket, which you and the administration propose, is highly sensitive to interest rates, and these have been declining very recently. As a result, the proposals are going to provide hospitals minimal adjustment for inflation in the period from 1983 to 1986 and probably 1987. The best estimates for 1986 is the inflation adjustment will be 0.2 percent in 1986 and minus 1.2 percent in 1987, giving hospitals less money for capital in 1987 than they had in 1986.

If, however, interest rates go up in 1987, capital payments could increase substantially.

As one of the developers of the current hospital market basket—and I have enclosed an article which I wrote about it—I recommend that you use the entire HCFA market basket price index or that you spend a lot more time developing a new capital index. The current capital index which the administration has proposed to use just does not work.

In table 1 in the accompanying data, what I show is the percentage of capital that go to individual hospitals. And what it shows is that the overall average developed to capital is 7.1 percent, but it is 8.3 percent in for profit hospitals and 5.5 percent in State and local hospitals.

I compare that to similiar data that I did in 1981, and I see that the distribution is narrower. It is closer to 7 percent in most categories in 1984 than it was in 1981. You are going to have fewer outlyers in 1984 than you do in 1981.

One of the issues that I think you really have to pay a great deal of attention to is the small rural public hospitals, hospitals which have used Hill-Burton funds recently. And these hospitals are going to have trouble purchasing capital in the future because they are going to have to pay a lot higher interest rates.

One of the programs that has been developed is the HUD-242 program to help hospitals ensure capital, and that just has not worked in the past.

I would be glad to answer any questions that you have.

Senator **Durenberger**. Thank you.

[The prepared written statement of Dr. Anderson follows:]

THE CENTER FOR HOSPITAL FINANCE AND MANAGEMENT
THE JOHNS HOPKINS MEDICAL INSTITUTIONS

624 North Broadway Baltimore, Maryland 21205 (301) 955-2300

STATEMENT

BY

GERARD ANDERSON, PH.D.

BEFORE THE

SENATE FINANCE COMMITTEE

SUBCOMMITTEE ON HEALTH

MARCH 14, 1986

Mr. Chairman:

My name is Dr. Gerard Anderson and I am an Associate Professor at the Johns Hopkins University and the Associate Director of the Johns Hopkins Center for Hospital Finance and Management. Before going to Johns Hopkins, I helped develop the Medicare Prospective Payment legislation while I worked at the U.S. Department of Health and Human Services.

I believe that prospective payment for capital is a necessary addition to the Medicare Prospective Payment System (PPS) and that legislation similar to what Senator Durenberger proposes is necessary to encourage hospitals to remain efficient and to become prudent purchasers. In my testimony, I would like to cover three topics:

- why prospective payment for capital is necessary,
- a comparison of the various proposals, and
- additional provisions that should be considered.

Why Is Prospective Payment for Capital Necessary?

Analysis of the long term trend in the ratio of capital to operating costs shows that the ratio remained relatively constant in the period from 1970 to 1982, averaging slightly less than 7 percent. However, during 1983 and 1984 the ratio began to increase and preliminary indications suggest that there was a substantial increase during 1985. The percentage of the hospital's budget spent on capital (not including return on equity) increased from 6.6 to 7.1 percent from 1981 to 1984 (see Table 1 and the Health Affairs article). This suggests that hospitals are making capital purchasing decisions to maximize their Medicare payments. By combining payments for capital and operating costs, this problem will be eliminated, since hospitals will not have a financial incentive to overinvest in capital.

A related advantage of incorporating capital into PPS is that payment levels would be linked to what the hospital produces and not how the production is generated. Hospitals will no longer have financial incentive to engage in what some economists have called "conspicuous production."

A Comparison of the Various Proposals

Since the passage of the prospective payment legislation, a number of capital payment proposals have been offered. Paul Ginsberg and I discuss these various proposals in an article, which I have enclosed with my testimony. In general, the various proposals differ along three dimensions: (1) the level of aggregate expenditures on capital, (2) the method for allocating capital to individual hospitals, and (3) the "phase in" methodology.

1. Aggregate Spending

An initial position of most proposals is that the aggregate level of capital expenditures should be equal to expenditures in some base period trended forward for inflation. Most empirical attempts to define capital needs require numerous assumptions and lead to widely differing estimates of need. Basing the level of expenditures on some base period adjusted for inflation is the preferred alternative of most analysts.

One significant difference between the Administration's and Senator Durenberger's bill is the inflation adjustment methodology. From 1983 to 1986, the Administration uses the capital component of the HCFA Market Basket Input Price Index, while Senator Durenberger uses the entire Index. The capital component of the Index is highly sensitive to interest rates, which have been declining recently. As a result, the Administration's proposal will provide hospitals almost no adjustment for inflation in capital costs from 1983 to 1986, while Senator Durenberger's bill would make adjustments. From 1987 to 1990 the Administration proposes to update the hospital specific portion using the capital component of the Index. If interest rates rise during this period, Medicare payments for capital could increase substantially. Senator Durenberger's bill would continue using the entire index. As one of the developers of the Index, I can assure you that its capital component was not designed to be used alone (article attached). My recommendation is that either the entire HCFA Market Basket Price Index be used or that a new and improved capital index be developed.

2. Allocation to Individual Hospitals

In general, most proposals can be divided into two categories: cost based options and prospective options. In our review of the cost based options (which link capital payments to each hospital's capital costs) Paul Ginsberg and I conclude that none of the cost based options create the proper incentives for efficient management.

Most of the prospective options suggest combining capital and operating expenditures into a single payment. In Table 1, I present the percentage of hospital expenditures spent on different types of hospitals for 1984. For example, while the overall average is 7.1 percent, it is 8.3 percent in for-profit hospitals and 5.5 percent in state and local hospitals. This table demonstrates that combining the payments at a uniform rate would benefit certain hospitals and would penalize others.

The various prospective options use somewhat different methodologies but would reach similar payment levels at individual hospitals. One major difference among the various proposals is whether an across-the-board add-on or DRG-specific add-on should be used. Analysis of the data suggests that the payment level to individual hospitals would be the same under either scenario.

One major unresolved issue is whether to include the direct and indirect allowance for graduate medical education in calculating the capital payment. In the Administration's proposal these costs would not be included. My studies of teaching hospitals suggest, however, that education requires space. Most architectural firms allocate 1500 square feet per bed in teaching hospitals compared to 1000 square feet in non-teaching hospitals because it is frequently necessary to have several residents learn at the patient's bed side. For this reason, I believe that the teaching adjustment should be included in the capital payment.

3. "Phase-In" Transition Methodology

A major issue in all proposals is how to establish a transition period that simultaneously allows hospitals that need to build to accumulate capital and allow hospitals that have recently built to retire their obligations. Senator Durenberger's and the Administration's proposal differ in two major areas: the method for calculating the hospital-specific proportion and the length of the transition.

Senator Durenberger uses a "rolling base" that calculates the hospital specific proportion based on the hospital's actual capital costs during that year, while the Administration proposal would limit capital payments to 1986 capital costs adjusted for inflation. I believe that it is necessary to use actual costs in order to assist hospitals whose capital projects will begin in the 1986 to 1990 period. In addition, a formula that gives hospital-specific proportion more weight in the early years will permit a shorter transition period and cause less disruption in the capital markets.

Economic calculations suggest that the length of the transition period should be seven years in order for most hospitals that have built recently to be able to return to the industry-wide average level of capital expenditures. However, since the PPS legislation announces that any capital projects started after April 1983 may be subject to the new rules, it can be argued that the transition has already begun. I would favor a five year transition that is weighted toward the hospital specific component in the early years.

Additional Provisions

One of the ultimate goals of the prospective payment system for capital, I believe, is that hospitals should be able to purchase the same amount of bricks, mortar, and major movable equipment with the capital payment. Unfortunately this is unlikely to be true.

Small rural hospitals, public hospitals, and hospitals that have used Hill Burton funds generally will have to pay higher interest rates than other hospitals. These hospitals have difficulty receiving private loan insurance or letters of credit, which can substantially lower the cost of long term borrowing. One possible way for these hospitals to receive loan guarantees is through the HUD 242 program. However, only 300 hospitals have benefitted from this program in the past 15 years. In addition, final regulations allowing public hospitals to participate in this program have never been promulgated. If Congress is going to pass a prospective payment system for capital, it should also consider steps that will equalize access to capital across hospitals.

The Administration proposes to make no adjustments for the cost of capital among regions of the country, aside from rural/urban differences. Although I have no data to support this, it would seem logical that construction costs would be higher in certain major metropolitan areas. In downtown Minneapolis, for example, land values would be higher, it would be more difficult to build, and the insulation required to withstand Minnesota winters would be greater than in some suburban areas in other regions of the country. For this reason, an adjustment for the cost of construction across areas appears warranted.

Mr. Chairman, I recognize that this testimony has been rather technical, and I would be pleased to answer any questions.

TABLE 1

HOSPITAL CAPITAL COSTS, AS A PERCENT OF TOTAL COSTS, 1984

		Percentage of Hospitals with Capital Payments in Interval					
	Mean Percentage	Less Than 4	4-7.1	7.1-10	10-15	15-20	Greater Than 20
All Hospitals	7.1	18.0	36.5	30.4	10.9	2.8	1.3
Ownership							
Not for Profit	7.6	13.6	31.4	35.1	15.0	3.5	1.4
For Profit	8.3	7.8	27.7	51.3	8.3	2.6	2.2
State and Local	5.5	31.6	50.8	10.4	5.0	1.7	0.6
Beds							
Less than 50	5.9	23.1	58.9	10.7	4.4	1.4	1.4
50-100	7.3	17.3	35.6	32.6	9.4	3.2	2.0
100-200	7.9	13.2	29.0	39.4	12.8	3.9	1.6
200-400	7.8	13.4	25.1	39.6	17.8	3.5	0.6
More than 400	6.0	28.3	34.2	26.4	9.8	1.1	0.1
Expenses per Day							
Less than $250	5.8	28.7	43.6	23.0	2.9	0.7	0.9
$250-450	7.1	15.7	37.9	32.2	11.0	2.5	0.7
$450-525	8.1	11.8	30.0	34.0	17.7	5.0	1.5
More than $525	7.9	14.2	30.9	33.2	15.0	4.3	2.4
Occupancy Rate							
Less than 60%	7.2	15.9	40.4	30.0	8.9	2.9	1.9
60-70	7.7	12.8	33.2	35.1	13.4	4.2	1.2
70-80	7.2	14.9	36.9	31.3	14.0	2.1	0.7
More than 80	6.0	33.6	29.9	25.1	8.9	2.1	0.5
Council of Teaching Hospitals							
Member	6.7	15.5	46.2	24.6	11.2	2.1	0.3
Not a member	7.1	18.1	36.0	30.8	10.9	2.9	1.3
Percent Medicare Admissions							
Less than 20	4.9	48.9	30.5	13.7	4.0	1.2	1.7
20-40	7.6	11.8	34.3	37.6	12.1	2.9	1.3
More than 40	7.1	15.6	43.9	24.2	11.9	3.5	1.0
Percent Medicaid Admissions							
Less than 5	7.1	21.5	28.7	31.6	12.8	3.8	1.6
5-15	7.2	14.3	39.4	32.2	10.4	2.6	1.0
More than 15	6.5	28.9	34.9	21.6	10.5	2.3	1.8
Census Region							
Northeast	6.4	26.9	31.9	27.7	10.2	2.6	0.7
North Central	7.1	18.6	37.7	25.6	13.7	3.1	1.3
South	7.4	14.3	37.2	34.4	10.0	2.8	1.3
West	7.1	16.8	37.5	32.2	9.2	2.8	1.6

Source - American Hospital Association - Annual Survey of Hospitals

Senator DURENBERGER. Our final witness is Hugh Long. Hugh, we welcome you back to this endeavor. I appreciate your input into my first capital bill. And any observations you want to make on where we have come since then, I would appreciate them.

STATEMENT OF DR. HUGH W. LONG, ASSOCIATE PROFESSOR OF CORPORATE FINANCE AND HEALTH SYSTEMS MANAGEMENT, A.B. FREEMAN SCHOOL OF BUSINESS, TULANE UNIVERSITY, NEW ORLEANS, LA

Dr. LONG. Thank you, Mr. Chairman.

My name is Hugh Long. I am an associate professor at the A.B. Freeman School of Business at Tulane University. Since 1981, I have also served as a health policy advisor to Congressman W. Henson Moore and was actively involved with Mr. Moore in moving PPS through the House Ways and Means Committee in 1983.

At that time, we said to the world, clearly we thought, that the Congress intended to roll capital payments into the prospective payment system. The speed with which it was necessary to act on PPS at the time precluded our doing so. But the time has now come to deliver on that original promise.

I would note that if S. 2121 were to become effective October 1, 1986 with its 7-year transition, we would, in effect, have a 10-year transition from the time of the notice which we gave the hospital industry in 1983 with respect to the roll together of capital and noncapital payments.

We have heard a lot today about the nature of capital costs, and the fact that these arise from decisions that are long term in nature and are more difficult to reverse than are operational decisions. But the reality is that capital decisions are not forever. And much of what we have heard today (including the estimates of how much money would be lost by various institutions under either the administration proposal or S. 2121) depends on the assumption that the managers of the provider institutions in this industry will be doing nothing between now and the indefinite future, once one of these proposals becomes law or regulation.

The reality, however, is that managers can and do manage capital decisions all the time. Organizations do change their capital structures. They do refinance their debt. They do raise capital in the equity markets (common stock in the case of for-profit providers or grants and philanthropy in the case of not-for-profit providers) and they do retire debt with that equity. They change their dividend decisions all the time: more or less charity care, more or less support of teaching or research, more or fewer dollars distributed to shareholders. They change their asset portfolios; they change their labor/capital intensity by managerial decisions every day. So we are not talking about a reality that says, "Gee, I entered into a bond arrangement that runs for 30 years" or "Gee, I bought a 40- year hospital building, and I cannot do anything at all about it until the maturity of that liability or the maturity of that asset."

The reality is that most financial decisions can be changed within a 7-year horizon. Indeed, a promise of making a principal or an interest payment of a dollar 30 years from now is of much less economic import than the promise to make such a payment 1 year from now or 7 years from now.

If I agree today to a 30-year, 12 percent debt obligation having equal annual principal and interest payments, and then say to you, "Oh, I'm sory, I don't think I can make any payments at all after 7 years," how much of the original amount would you still be willing to lend to me under those circumstances? The answer is that for fewer than one-fourth of the payments you would still be willing to loan me 57 percent of the amount that we originally talked about.

This is because of the payments up front have much greater economic value.

We are not talking in S. 2121 about going to zero at the end of 7 years, and we are talking only about Medicare which represents only 40 percent of the action. So, by and large, most debt obligations can easily be restructured within the constraints we have been talking about.

In terms of institutional winners and losers, who are the real losers? The losers are not defined by those who have 12 percent of their costs in the capital column as opposed to a national average of 7 percent. The real losers are the institutions having very low occupancies but that are now getting a large proportion of capital costs reimbursed because Medicare represents a large proportion of that low occupancy. Those are the real losers.

And who do we want to be the losers? On balance, exactly those institutions. Over the next 7 years, most forecasters expect that 20 to 30 percent of the acute care beds in the United States should disappear. Which ones? They should be the ones associated with inefficient providers. And the type of proposal that we are talking about here will produce as losers within the system precisely those inefficient providers that we would be better off without as we try to move to a more efficient delivery system.

Thank you.

Senator **Durenberger**. Thank you very much.

[The prepared written statement of Dr. Long follows:]

Hearings before the Subcommittee on Health
United States Senate Committee on Finance

March 14, 1986

Statement of Hugh W. Long, Ph.D.

Associate Professor of Corporate Finance and
Health Systems Management

A. B. Freeman School of Business

Tulane University
New Orleans, Louisiana

Introduction

Mr. Chairman, thank you for providing me the opportunity to present my views on Medicare capital payments and the regulatory review of capital expenditures. My name is Hugh W. Long. I am a member of the faculty at the A. B. Freeman School of Business of Tulane University, and for the past seventeen years I have engaged in academic work applying the principles of business economics and corporate finance to the management of healthcare and medical care services. Since 1981, I have also served as a health policy advisor to Congressman W. Henson Moore.

Issues

I should like to discuss two issues with you today. First, what is the most equitable way to terminate retrospective capital cost payments under Medicare and incorporate payment for capital in the prospective payment system? Second, are there any compelling reasons to continue regulatory approval of capital expenditures once the change in the payment system has begun?

Equitable Transition

On its face, there is no long-run economic rationale for the purchase of any good or service for both (1) a price that covers materials, labor, and energy, and (2) a separate side payment for capital-related costs. When the nation pays a Senator's salary, it doesn't write two checks, one for which is labeled "Payment for Your Services" and one of which is labeled "Reimbursement of Interest on Your Bank Loan." The only reason we are currently "writing two checks" for services for Medicare beneficiaries is that in 1983 the Congress correctly recognized the potential inequities of forcing into the same transitional mold altered payment mechanisms for both short-term and long-term factors of production.

Any alteration of any payment mechanism, even if neutral in aggregate, will necessarily leave some hospitals with either more dollars (the "winners") or fewer dollars ("the losers") than without the alteration. The purpose of any phased transition is to give managers of individual institutions sufficient notice to allow them to take specific action to minimize any deleterious effect of receiving fewer dollars. That is, we should permit managers to do what managers are paid to do, namely exercise sufficient control over their environments so as not to be "losers."

Capital "costs" arise from the financing of hospitals and the acquistion of assets by hospitals. These activities have effects ranging over many years and tend to be more difficult to reverse in the short term than other operational decisions. Thus, fairness requires a longer and more gradual transition for changes in capital payment than was necessary for the change in operational payments from a retrospective cost-base to a prospective DRG-base.

S. 2121, the "Fair Deal Capital Payment Act of 1986," meets this fairness requirement by (a) using a seven-year transition, and (b) weighting payments in the first four years of the transition so as to reflect predominantly each hospital's specific asset mix and financing mix.

Seven years is a sufficiently long transition that managerial decisions at provider institutions can be trusted to reflect rational self-interest, rather than relying on complex and costly regulations attempting to distinguish between "old" and "new" capital, or "equipment" and "nonequipment" usages, or arbitrarily forecasting useful lives of assets into the next century. Seven years provides a reasonable but finite period after which the vagaries and inefficiencies encouraged by the current system can generally be put behind us.[1]

A seven-year period is longer than the depreciable life of, or lease terms on, almost all medical equipment. It represents more than two-thirds of the duration[2] of almost all existing debt financing, and it is clearly a sufficient period during which managers can restructure capitalization, labor/capital intensity, lease and rental agreements, and make other changes as appropriate to increase the efficiency of an institution's use of capital.

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[1] For example, under the current system, two hospitals having identical total capital costs could receive very different dollar amounts of capital cost reimbursement. A hospital 80% occupied will receive only half the payment per Medicare-occupied bed that will be paid to an identical hospital 40% occupied. And the latter hospital will receive more total dollars as well, if the proportion of its occupancy that is Medicare is larger than the proportion of Medicare patients in the first hospital, since it is that proportion of total capital costs that is reimbursed.

Assuming a provider has optimized Medicare capital payments under the existing system, the seven-year horizon minimizes the imposition of penalties on the institution for its managers having done what we paid them to do, while simultaneously providing increasingly positive incentives each year not only to structure new financing and asset arrangements consistent with the economic efficiencies associated with prospective rates, but to restructure existing arrangements as well.

Nor does the transition as structured unduly mitigate against the institution now in need of modernization or expansion. Even at the beginning of the transition, such a provider is a small "winner," and because of the long-term nature of such decisions taken now, their effects will clearly transcend the first half of the transition and be evaluated primarily on their economic merit in a future environment of total prospective payment.

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[2] "Duration" is a technical finance measure of the average length of time required to recapture value. For example, the duration of a brand new 15-year, 12% mortgage with level annual payments of principal and interest is only six years. At the end of seven years, only 47% of the mortgage's life will have elasped, but nearly 63% of the total interest will have been paid, and over 67% of the total value of all payments will have been made.

I would caution, however, of the potential danger to nonprofit providers should the Congress establish in S. 2121 such incentives for restructing capitalization, but then proscribe the attainment of such efficiencies per the restrictions currently contained in H.R. 3838, the "Tax Reform Act" as it relates to the issuance of tax-exempt securities, particularly advance refunding.

1122 Review

As long as we agreed to pay some portion of capital costs, whatever amount they were, and allowed that amount to be determined independently by providers, it was virtually self-evident that there would be more rather than fewer capital expenditures, barring regulatory control. That, as I see it, was the only compelling rationale for Section 1122 reviews.

Once we begin the transition away from the current commitment to pay retrospectively, we remove the 1122 rationale and should therefore remove 1122.

This reasoning is independent of any verdict on the past efficacy or costs of this regulation. This picture is mixed, but there is at least some evidence that 1122 has been more effective in influencing the mix of expenditures than in limiting the aggregate level of expenditures. There is anecdotal evidence that by limiting competition (pejoratively referred to as "duplication"), health care costs have been increased to nonentitlement program patients even as entitlement program capital costs have been held in check. And some urban providers complain that 1122 has kept them from attracting the charge-paying business that would have allowed them to maintain higher levels of care for the medically indigent.

Nor should Section 1122 be equated with "health planning." 1122 is simply having a central authority decide "who gets what," based on noneconomic criteria such as "need," a term I have yet to see defined in a measurable way with respect to the dynamic environment of medical knowledge and technology. Such resource allocation by fiat has little to do with planning, the formulation and dissemination of forecasts of the supply and demand for services, technological progress, and the competitive environment, in short the information individual institutions can use to make their own resource allocation decisions, including capital expenditures.

And making all of their own resource allocation decisions is exactly what we should want institutions to do, and what they will do once we begin the transition away from retrospective capital cost payment and terminate Section 1122 reviews.

Conclusion

In the final analysis, we need to move in a deliberate, orderly way to a system in which (1) a single price is paid for an identifiable unit of output, and (2) the provider of that output is solely and wholly responsible for deciding how best to command and array resources to produce that output--labor intensive/ capital intensive, make and sell/buy and resell, leased/owned, unlevered/levered, short-term loans/long-term debt, etc. This is the road to innovation, total cost efficiency, and quality care.

Thank you.

Senator **Durenberger**. First, a question of Mr. Kalison. I was going to ask about your conclusion that quality of care will improve if capital to resources are better allocated, but Senator Bradley gives me an illustration of that question.

We know that capital costs vary substantially across DRG categories. A hospital that does a lot of tonsillectomies has different capital costs than a hospital with a lot of cancer patients. Unless we recognize these differences in the Medicare capital rates, won't we create incentives for hospitals to avoid treating patients with diseases associated with high costs?

Mr. **Kalison**. We concur.

Senator **Durenberger**. Pardon?

Mr. **Kalison**. We concur.

Senator **Durenberger**. All right.

Mr. **Kalison**. I think our point was that by associating the cost correctly with the DRG's that over the long term you will put the right amount of money in the right hands. Instead, you will replicate successful programs; that is, programs with a lot of volumes, and other ones which should terminate will terminate because you will drive the capital for them. You want to make that micro decision very, very accurate, as accurate as you can.

Senator **Durenberger**. Dr. Anderson, would you elaborate on the statement you made about the capital components of the market basket? I saw Kathy flinch back there.

Ms. **Means**. I agree.

Senator **Durenberger**. Oh, you agree. I hope that is on the record.

Just elaborate on it a little more about why you recommended that the capital component of the market basket of the index not be used all by itself but we use the whole. I think you said use the whole of the market basket, right?

Dr. **Anderson**. Right.

About a third of the capital market basket is the interest rates. And the interest rates that we included in the original market basket is a 5-year moving average of either the prime rate or long-term bond rates, both of which have declined substantially in the last 5 years, which means that that component of the capital market basket is very negative—minus 5, minus 6 percent. When you then add it to the other two-thirds of the capital market basket, which is depreciation, that gives you an overall average which is about zero for most of the last 5 years, which means that if you state start in 1983 and you move through 1987, there is no inflation adjustment for capital.

And that is where you get an awful lot of your budgetary savings in the administration bill.

Senator **Durenberger**. I see.

Dr. Long, you note that for hospitals that optimize Medicare capital payments under the existing system the 7-year transition period will be sufficient to permit structuring of new and existing capital arrangements. First, what do you mean by 'optimized?' And then what is the impact on institutions that did not optimize Medicare payments?

Dr. **Long**. By optimized, I mean the extent to which hospitals and their managements responded to the affirmative incentive to substitute capital for labor because of the differential payment mechanism for those two factors of input.

I am sorry, sir, the second part of your question was?

Senator DURENBERGER. What is the impact on institutions that did not optimize Medicare payments?

Dr. LONG. Well, to the extent that there was not that substitution effect or to the extent that with respect to the capital cycle discussed earlier by other witnesses, those institutions would be those that would be the nominal winners under any transition formula that included weights for the national average that these institutions were below.

I am not terribly concerned about the nature or amount of those payments, and I would characterize them not as windfalls, but as simply a part of a fair long-run payment for services rendered. I again would agree with the earlier testimony that what individual institutions might do with those differential moneys in the early years of the transition is not really a matter affecting policy in any major way. Individual institutional decision makers should be allowed to decide how they wish to allocate those resources.

Senator DURENBERGER. Gentlemen, thank you very much. We have some additional questions to submit to each of you for responses in writing. And we are grateful for you coming here and for the continued contributions to this effort to reform the health care system.

Thank you very much. The hearing is adjourned.

[Whereupon, at 12:42 p.m., the hearing was concluded.]

[By direction of the chairman the following communications were made a part of the hearing record:]

THE CENTER FOR HOSPITAL FINANCE AND MANAGEMENT
THE JOHNS HOPKINS MEDICAL INSTITUTIONS

624 North Broadway Baltimore, Maryland 21205 (301) 955-2300

April 1, 1986

Edmund J. Mihalski, C.P.A.
Deputy Chief of Staff for
  Health Policy
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Ed:

I enjoyed testifying at the capital hearing. If you hold any hearings on financing of graduate medical education or capitation pricing, I would be pleased to testify. If you are planning to have hearings on any of these topics, I would be happy to provide background information.

I am enclosing responses to the questions on capital.

Sincerely,

Gerard

Gerard F. Anderson, Ph.D.
Associate Director

GFA/tmm
Enclosures

1. There are two reasons for including the adjustments for teaching in the capital payment:

   1) Much of the adjustment for teaching has nothing to do with medical education, but instead it is an adjustment for factors that the DRG system does not take into account. These factors--severity of illness, inner city location, etc.--are correlated with higher capital costs. It requires more capital to treat a severely ill patient and it is more expensive to build a hospital in an inner city environment.

   2) Educational programs require additional space. As I mentioned in my testimony, hospital rooms in teaching hospitals are built 50 percent larger to accommodate students at the patient's bed side. Educational programs require office space and other facilities that involve capital expenditures.

2. I believe that the hospital specific proportion should be based on actual costs for four reasons:

   1) There is a very long period of time between when hospitals decide to build and when the construction is completed. As a result it is very possible to have secured financing in 1982 or 1983 and not have incurred major capital expenses until 1987. Basing the hospital specific proportion on the actual cost would eliminate this problem.

   2) Because there is a long time period between the decision to expand and the time that expenses are actually incurred, using actual costs would not cause hospitals to engage in an expansion boom.

   3) Basing the hospital specific proportion on actual costs would permit a shorter phase in period. Most of the requests for a long phase in come from hospitals that have just built or hospitals that have major construction projects underway.

   4) By careful design of the phase in methodology, it is possible to develop a "budget neutral" proposal.

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United States Senate
COMMITTEE ON FINANCE
WASHINGTON, DC 20510

March 20, 1986

Mr. Michael D. Bromberg
Executive Director
Federation of American Health Systems
1111 19th Street, N.W.
Suite 402
Washington, D.C. 20036

Dear Mr. Bromberg:

To follow-up on your testimony at the March 14, 1986 Subcommittee on Health hearing on reform of Medicare reimbursement for capital expenses, Senator Durenberger would like you to answer the attached questions.

Your response should be typed on letter-size paper and double spaced. To meet our printing schedule, please provide your answer no later than April 10, 1986. Send your response to:

United States Senate
Committee on Finance
Attention: Shannon Salmon
Washington, D.C. 20510

If you have any questions, Ms. Salmon may be reached at 202/224-4515.

Sincerely,

EDMUND J. MIHALSKI, C.P.A.
Deputy Chief of Staff
for Health Policy

Questions for Mr. Bromberg

1. Why is any period less than ten years and inadequate transition period?

2. I was interested in the following comment in your statement:

   "If the Medicare program is unwilling to contribute its fair share toward needed capital improvements in our health system, then Congress should recognize that such improvements constitute "non-covered services" and can be charged to patients".

   How do you define "fair share"?

(C0422)

RESPONSES BY MR. BROMBERG

1. Hospitals which undertook large capital financing projects in the early 1980's face long term debts - perhaps thirty years. A transition of even 10 years merely postpones the economic harm. Unless old capital is protected a transition period leaves such institutions helpless to change their obligations through any management actions.

2. Government's "fair share" of capital payments is simply a payment level adequate to reflect efficient management of a facility's capital needs. Ideally that payment level should be determined in the marketplace; however, since Medicare unilaterally sets prices, that is not happening today. One way to change that would be to allow hospitals to charge for capital projects not adequately funded by Medicare as they now may charge for non-covered services. Absent such a change, a budget driven price regulation system will lead to government rationing rather than consumer choice.

American Hospital Association

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May 2, 1986

Edmund J. Mihalski, C.P.A.
Deputy Chief of Staff
for Health Policy
United States Senate
Committee on Finance
Washington, D.C. 21510

Dear Ed

Please find attached my response to questions posed by Senator Durenberger as a part of the Subcommittee on Health hearing on reform of Medicare reimbursement for capital expenses.

If you have any questions about this, please call Mike Rock at 202/638-1100.

Sincerely

Jack

Jack W. Owen
Executive Vice President

American Hospital Association

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Response to Questions Posed by the Subcommittee on Health of the Committee on Finance

1. Your testimony indicates that AHA would not support splitting payments for moveable equipment, and fixed equipment/plant. Since the useful life of moveable equipment generally is recognized to be quite short and fixed equipment and plant have a relatively long useful life, doesn't it make some sense to split the payments. If not, why?

AHA does not support splitting capital payments between moveable equipment and fixed equipment/plant costs by incorporating the former fully at one time and the latter gradually over a lengthy transition period for the following reasons:

- the immediate incorporation of moveable equipment costs without a transition to recognize institution-specific actual costs presumes that all hospitals have the same ratio of moveable equipment costs to operating costs. In fact moveable equipment costs vary substantially among hospitals such that immediate and full incorporation of such costs would be inequitable, resulting in windfall payments to some hospitals and substantial shortfalls in payments to other hospitals.

- it is not clear what, if any, benefit is obtained by separating capital costs in the manner proposed since a lengthy transition is necessary for fixed equipment/plant costs in any case. In addition to the inequities that result, such a separation is administratively complex and burdensome because it would require detailed cost accounting and reporting for the purpose of identifying non-moveable equipment capital costs for computation of the institution-specific payment during the transition for such costs.

The AHA believes that the costs and negative consequences associated with incorporating capital costs in the manner proposed are substantial and unnecessary, especially given that no clear benefit has been identified for doing so.

2. You estimate that hospitals may experience as much as a 30 to 50 percent deficit in Medicare capital payments after the transition period proposed in S. 2121. What is that estimate based on? Are certain hospitals more likely than others to experience such reduction? If so, which ones?

The estimate of a 30-50% shortfall in Medicare capital payments to hospitals associated with S. 2121 represents the difference between the value of the national capital add-on amount based on estimated actual capital costs in 1986 versus the computation method proposed in S. 2121. The shortfall is caused by three factors:

- adjusting the hospital capital cost base to exclude return on equity payments and to include an offset of interest income against interest expense;

- using a market basket factor rather than actual capital cost increases to roll forward the newly defined base year capital costs (presumably 1983 costs) to the year immediately preceding incorporation; and

- apportioning capital costs in relation to 1983 Medicare admissions rather that Medicare admissions in the year immediately preceding incorporation.

Generally, all hospital are negatively impacted by any incorporation method that reduces the national capital add-on amount to less than that which is adequate based on actual capital costs in the year immediately preceding incorporation.

Hospital most seriously impacted are those that have recently incurred major capital expenditures or may need to do so in the near future. In this regard, implicit in incorporation methods that propose a 1983 base and/or that distinguish "old" and "new" capital is the assumption that capital spending after a given date, e.g., April 1983, is either unnecessary or irresponsible. The AHA rejectd this assumption. Hospitals obligate major capital expenditures in capital spending cycles that extend over many years. Such expenditures are often non-discretionary or unavoidable, especially when they are made in response to regulatory and accreditation standards.

The AHA believes that any capital payment method that attempts to treat capital costs incurred after a specific past date differently from those incurred before that date is patently unfair and should be rejected.

The Catholic Health Association
OF THE UNITED STATES
CHA

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202 - 296-3993

May 2, 1986

Edmund Mihalski, C.P.A.
Deputy Chief of Staff
for Health Policy
Senate Finance Committee
219 Dirksen Senate Office
Building
Washington, D.C. 20510

Dear Ed:

Attached is our response to the question posed by Senator Durenberger as a result of the testimony given by William Cox on March 14, 1986 before the Subcommittee on Health.

Sincerely,

Thomas J. Gilligan

TJG:jmm

Enclosure

Question for Mr. Cox

1. Why did so many of your member hospitals initiate large capital investments when Congress announced its intention in 1983 to introduce a prospective payment for capital under Medicare?

(C0423)

One can only speculate to the exact reasons why so many Catholic hospitals have acquired new capital since 1983.

I would point out that increased recent activity in capital markets stem at least in part from two movements within the hospital sector. The first movement is toward multi-hospital systems, the second movement was among multi-hospital systems toward a financing device called master trust indentures.

Many in the hospital community and many observers saw and continue to see the move to multi-hospital systems as a very positive phenomenon. Multi-hospital systems can bring sophisticated management to smaller hospitals that can't afford such high priced talent. Financially stressed hospitals that serve the poor can continue to do so with the backing of a financially healthy hospital system. Many observers also view the move to multi-hospital systems inevitable as the hospital sector goes through a "shake-out" caused by PPS, HMOs, PPOs, etc.

Catholic hospitals have found it very easy to move into multi-hospital systems. Since most of the religious orders and the dioceses that sponsor hospitals sponsor more than 3 hospitals, the framework for the multi-hospital system was already there.

In calendar year 1986 over two thirds of CHA's 625 member hospitals are in multi-hospital systems.

The second phenomenon of master trust indenture followed directly on the heels of the movement of multi-hospital systems. Almost as soon as multi-hospital systems formed they sought to consolidate the current debt of individual hospitals at the systems level. Further debt of the systems hospitals would be borrowed based on the financial strength of the system at lower interest rates and without restrictive covenants.

It is quite probable that the borrowing that went on in 1983 and 1984 and early 1985 was obligated prior to the magic date of April 1983.

Just a word about the nature of the capital projects entered into by Catholic hospitals. Nearly half of the projects involve no new beds. These projects involve reduction in bed size, new ancillary services or some other non-inpatient project. Of those projects that did involve new beds, all but two have involved a small number of beds, i.e., 10 beds for alcohol detox, rehabilitation, psychiatry, etc. Only two involved a substantial number of new beds. And both of these hospitals were in areas of the country that were experiencing substantial growth in their population.

HFMA

HEALTHCARE
FINANCIAL
MANAGEMENT
ASSOCIATION

RONALD R. KOVENER,
FHFMA, CAE
VICE PRESIDENT

1050 17TH STREET, NW
SUITE 510
WASHINGTON, DC 20036
TELEPHONE 202 296 2920

April 18, 1986

United States Senate
Committee on Finance
Attention: Shannon Salmon
Washington D.C. 20510

Dear Ms. Salmon:

In response to Senator Durenberger's questions contained in Mr. Mihalski's letter of April 7, 1986, the Healthcare Financial Management Association (HFMA) is pleased to provide these additional views:

Question 1: Is it reasonable to expect most hospitals with high capital expenditures to be able to use operating revenue and internal sources of cash to get through a seven year transition period such as the one proposed in S.2121?

A hospital's ability to cope with any transition period to a new system of Medicare payment for capital depends on such factors as:

(1) The nature of its capital expenditures.

(2) The reasonableness of payments for capital and operating costs during the transition period.

If a hospital has high capital costs due to recent acquisition of expensive equipment, the depreciation period for the equipment and the transition period may be of similar length and a high proportion of hospital-specific payments during the transition period may offer relief.

If high capital costs is due to high interest rates or a rapid loan repayment arrangement, a hospital may be able to restructure its borrowing to more closely match the payment arrangement.

The most severe and difficult problem will result from high costs resulting from recent acquisition of long-lived plant expenditures. These are the situations that cause HFMA the most concern. These plant capital expenditures have been made with full approval and in expectation of payment in accordance with current rules. These obligations cannot be changed because they are in the form of bricks, mortar, wiring, plumbing, etc. -- not renegotiable agreements.

In addition to use of current cost and discharge information for a heavy emphasis on hospital-specific rates during the transition, three changes in S.2121 can help address these problems:

a. Different transition arrangements can be provided for plant and equipment.

b. Special protections can be given "old" plant.

c. An exceptions arrangement can be added.

With respect to the differentiation between plant- and equipment-related capital, we believe the following points are relevant.

a. Different treatment of the two elements is appropriate because

   - The time horizon for planning and the duration of the time commitment once a capital decision has been made are substantially different for plant and equipment.

   - There are often opportunities for interchanging equipment for labor, but there are not often similar opportunities with respect to interchanging plant and labor. Since there are opportunities to interchange equipment and labor, we believe that payment arrangments for each should be consistent. Consistency allows management to evaluate these alternatives based on individual hospital circumstances.

   - There is a pronounced difference in capital cycles for plant and equipment. Plant expenditures are generally made on an episodic basis; equipment, on the other hand, is acquired and replaced in a relatively constant manner. Since equipment acquisition decisions are made more frequently, and more routinely, the financing of equipment is a more integral part of the routine financing plans of the institution. In contrast, plant expenditures often are financed with new debt issues, stock offerings, or similar special financing arrangements.

b. We believe the information to make a differentiation between plant and equipment is readily available in the hospital cost report information that has been filed with the Medicare program over many years. We believe that the Medicare program contains reasonably adequate definitions of each element. There may be some gray areas, but since the differentiation is only for a transition period, these questions should not offer a significant opportunity for program abuse. Furthermore, the amounts for both equipment and plant are quite small in relation to overall Medicare spending although these amounts are very crucial to each individual institution.

c. Incorporating equipment into the prospective price setting (PPS) rate more quickly than the plant component would subject these expenditures to the more arbitrary decision processes of the Secretary of Health and Human Services (HHS). Although we recognize the risk this implies, we continue to hope that all aspects of the rates of payment for Medicare services can be determined in a cooperative manner, in a spirit of good faith between the parties, and with the sound long-range fiscal health of the industry and individual institutions as a prime objective. If these basic principles are not followed, it makes little difference whether any element of hospital cost is paid on a cost basis or any other basis because the result will doubtless be a shortfall.

d. The immediate incorporation of equipment into PPS rates should allow an even longer transition for integrating plant capital cost into the PPS rate. HFMA considers a very long transition to be essential. Plant capital costs have a very long commitment period and the circumstances of individual institutions vary significantly without there being any identifiable pattern as to the cause of the difference. Accordingly, the individual circumstances of providers must be recognized through a very long transition period for plant capital costs. We urge that this transition be no less than 10 years in length.

With respect to the differentiation between "old" and "new" capital, we strongly support the protection of current capital commitments. Again, we stress the very long periods of time that are required to fulfill existing capital commitments and urge Congress to recognize that these commitments cannot be set aside or offset in the short run based upon new payment rules.

We would also point out that the government's role as a participant in various hospital capital commitments continues to this day. Therefore, current commitments deserve the same protection as commitments made three, five, or 10 years ago. Accordingly, any differentiation between "old" and "new" capital should be made from the standpoint of obligations and commitments on the date on which new rules are actually adopted, not from the date of legislation that vaguely implied that new rules might be adopted in the future.

If a differentiation between "old" and "new" capital is made (and we think there are persuasive arguments for making such a differentiation), it must also be recognized that Medicare's capital payments will barely be adequate to fulfill old commitments. Without "new money" there will be virtually no resources available to meet the needs of those institutions that need to renew their capital in the near future. If each hospital gets a small amount for new capital, this will exacerbate the problems of institutions that need to make new capital expenditures after new rules are adopted. (The special circumstances of facilities that will need to make new capital expenditures led HFMA's Capital Steering Committee to the conclusion, in 1984, that there was no alternative but for plant capital to continue to be paid on a cost pass-through basis.) The special needs of facilities that need new capital may have to be met with some form of supplementary funding during at least the early portion of a lengthy transition period. Similar protection is appropriate for facilities with high capital costs of unavoidably long duration. These funds should be available to needed facilities on the basis of an exception formula. A qualifying hospital, at the start of the transition or when a new expenditure is made, can calculate the excess of depreciation and other capital-related cost over Medicare's payment formula for each year of the useful life of the plant capital project in which a shortfall will occur. This one-time calculation can then serve as a basis of supplementary Medicare payments, based on actual Medicare utilization in each subsequent year.

In summary, it is not possible to draw a universally applicable conclusion concerning hospitals' ability to cope with a transition to new Medicare capital payment arrangements. Steps which can help overcome these problems are:

a. use of current cost and discharge data throughout the transition period;

b. heavy emphasis on hospital-specific costs during a long transition period;

c. different transition arrangements for plant and equipment;

d. special protections for "old" plant; and

e. an exceptions arrangement.

Question 2: How can we avoid an inappropriate redistribution of capital among providers in the development and implementation of a capital reform policy?

Similar to our response to question 1, a single formula cannot prevent inappropriate redistribution. Each hospital is in a unique position as a result of applying rules and relying on commitments during the over 20 years of Medicare's existence. New arrangements must not overlook this historic perspective. Provisions that could be added to S.2121 to avoid inappropriate redistribution include:

1. A very long transition period for plant capital. The longer transition for this element can be partially offset by the immediate integration of equipment into PPS rates.

2. Adequate payment for all cost -- operating and plant. Use of current cost and discharge data will help assure adequate payment.

3. An exception arrangement for unusual current commitments or essential new facilities.

If we can provide additional information on any of the above, please contact me or Ted Giovanis at 296-2920.

Sincerely,

R. R. Kovener
Vice President

RRK/dvw

NATIONAL ASSOCIATION OF PUBLIC HOSPITALS · 1426 Twenty-First Street N.W. Suite [illegible] Washington, D.C. 20036 (202) 861-0434

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MEMORANDUM

TO: SENATE FINANCE COMMITTEE

FROM: LARRY S. GAGE, President

RESPONSES TO SENATE FINANCE COMMITTEE QUESTIONS

SFC Question No. 1

Medicare appears to be a relatively small contribution to public hospital capital support. What impact would elimination of the pass through have on public hospital capital investment decisions?

RESPONSE

1. For most NAPH member hospitals it is true that state and local governments and Medicaid are larger sources of support than the Medicare program. However, Medicare represents approximately 58% of revenues among the insured patients of NAPH member hospitals. Just 41 NAPH members received $702 million in Medicare revenues in 1983, or over $17 million per facility.

2. While NAPH member hospitals received about 17% of their revenues from Medicare in 1983, some of our member institutions relied on this payment source for as much as 37% of total revenues. For hospitals at these higher levels, Medicare capital restrictions would be particularly burdensome.

3. Medicare has often been used to set hospital reimbursement parameters at the state level. This "trend setting" influence may become even more important as states consider applying a prospective payment approach to other payers, especially Medicaid. Thus, reduction or restriction of Medicare capital payment is likely to encourage other payers to do the same.

4. The problems facing public hospitals if the Medicare capital pass through is eliminated will thus be intensified by the relative importance of Medicare as a proportion of the insured patients of many such hospitals. This will be true particularly if the transition period is brief (e.g., 5 years or less) and no special consideration is granted for these institutions. The Administration's proposed regulation -- to phase out the pass through quickly,

while paying hospitals only the lesser of their actual capital costs or the phased in national rate -- could cripple any attempts to improve the capital situation of many such hospitals.

SFC Question No. 2

Why do public hospitals need capital support? Isn't it because state and local governments have made deliberate decisions not to support them?

RESPONSE

1. During 1983, NAPH members' support from state and local governments averaged over 30% of all operating revenues, or $31.1 million per facility. Such a substantial level of funding, which generally includes equipment, minor renovations and repairs, and working capital, restricts greatly their ability to directly support major capital initiatives. As with other hospitals, such major initiatives must be financed instead through long-term tax-exempt financing.

2. From 1955 to 1979 municipal government spending support for health care has been substantial, increasing by 523% during that period. As of 1968 this support has reached $2.6 billion.

3. Most state and local government have traditionally provided major capital support for public hospitals, not through appropriations, but by general obligation (GO) bond financing which requires voter approval. Thus, final decisions are left to the citizens and are subject to the vagaries of any support that is voter-based. However, without the GO mechanism, public hospitals have a very limited number of options for capital financing. In fact, reports prepared by Don Cahodes and NAPH, and summarized in my testimony, indicate that philanthropy, private placements, conventional mortgages, and taxable sources of capital are non-existent or have decreased significantly and represent a very small basis of support for public hospitals. Tax exempt financing, as a percent of all capital financing, increased from 36.2 in 1973 to 80.6 in 1979.

4. Much of the support from state and local governments is used for maintenance of facilities with old, obsolete infrastructures (e.g., California hospital data summarized in my testimony). As a result, funds for capital projects are often required to respond to JCAH, state or grand jury life/safety code citations, leaving little for major plant and equipment replacement.

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Q+A
[illegible]

VIA FEDERAL EXPRESS

April 8, 1986

United States Senate
Committee on Finance
Dirksen Building
Room 219
Washington, D.C. 20510

Attention: Ms. Shannon Salmon

Dear Ms. Salmon:

Set forth below, please find our response to the questions posed by Senator Durenberger and Senator Packwood in your letter to me of March 20, 1986.

Question from Senator Packwood

1. Please elaborate on your conclusion that quality of care will improve if capital resources are better allocated. (C0430).

As in the case of other types of work, there is a positive relationship between quality and experience in health care; the more frequently a procedure is performed, the higher the likelihood of a successful outcome. This relationship is well-confirmed. See Luft, Burker & Enthoven, Should Operations be Regionalized? The Empirical Relationship Between Surgical Volume and Mortality, 301 NEW ENGLAND JOURNAL OF MEDICINE 1364 (1979). Unlike the current capital cost pass-through which merely rewards past management decisions (good or bad), the natural result of an add-on is to allocate capital resources in a manner consistent with patient volume. This is desirable because it will provide financial support to well-utilized programs, while sending a clear signal to phase-out those programs which fail to attract sufficient volume. However, although the add-on is a good first step, a further refinement is nevertheless needed to properly adjust for the fact that different kinds of patients require different kinds and amounts of resources, including capital.

In our written testimony we suggested that "...a patient undergoing coronary bypass surgery cannot be expected to require the same kinds and amounts of resources (including capital resources) as a patient facing an uncomplicated appendectomy." In our oral testimony, we utilized actual data from the Health Care Financing Administration to provide the following illustration: On the average, capital costs represent approximately 6.8% of total costs. Examining the percentage of capital costs by DRG, we observe the following kinds of variations - patients admitted to have a simple change of pacemaker battery (DRG 118) would require a capital component of about 4.1%. On the other hand, patients admitted for multiple trauma with significant complications (DRG 444) would require a capital component of 8.2%, or about double the percentage for battery replacement.

The example illustrates how major trauma centers might suffer if the capital component to the Prospective Payment System were simply a flat add-on of 6.8%. In contrast, a DRG-specific add-on would return to the hospital the appropriate amount of capital for each kind of case it treats. As a result, the total DRG payment for each hospital would be increased by different amounts depending upon each facility's case-mix, thus recognizing that hospitals have different overall capital requirements because of case-mix variations. To put it another way, the failure to incorporate this "fine-tuning" adjustment would lead to a significant misallocation of resources: Over time the hospital with a high proportion of "appendectomies" and battery replacements would enjoy a windfall, while the hospital treating a case-mix with more significant financial demands would suffer financial harm. By providing the appropriate amount of capital payment, the financial support of successful programs will be encouraged leading to an improved quality of care. Accordingly, a DRG-specific add-on is required to promote equiliberium in the health care system, over time.

Question from Senator Durenberger

1. Why do you think that hospital planning agencies will be more effective if their role is reduced? (C0430)

Prior to the enactment of the Prospective Payment System (PPS), Medicare reimbursed to the hospitals whatever they spent on patient care. In this environment of cost-based reimbursement, health planning agencies were developed as a "gatekeeping" device; a last line of defense before Medicare assumed its commitment. Under this financial framework, health planning agencies focused primarily on new capital investment. A variety of statistics were examined including bed counts, length of stay, projected occupancy, projected cost, and so forth. Although well-intended, in reality the planning process sometimes diverted hospital management away from consideration of the impact of real market forces. Considerable energy was often devoted to finding and developing that set of projections which would favorably influence the planning agency. In fact, the ineffectiveness of this elliptical process and theoretical approach to cost containment was a prime factor leading to PPS. Indeed, the power of financial incentives to overcome the best kinds of planning initiatives is well-illustrated in New Jersey where prospective payment was first applied to non-capital costs.

As we indicated in our written testimony: "...the New Jersey prospective payment system, with its capital pass-through, was proposed and enacted into law in 1979. In 1984, a report issued by the Governor's Advisory Committee on Capital Expenditures for Health Care Facilities ("Governor's Advisory Committee"), pointed out that between 1979 and 1981, while prospective payment was beginning to exert pressure on non-capital expenditures, the N.J. health care planning system approved $1.5 billion in capital expenditures - on a per capita basis, more than all but three states. The report goes on to point out:

> All these expenditures contribute to higher costs for patients. Because much of the capital investment during the past several years has been debt-financed, we only now are beginning to see these costs reflected in hospital rates. Capital reimbursement to hospitals increased more than 20 percent between 1983 and 1984 alone. Projections for the next two years show increases of between 10 percent and 20 percent a year (under existing reimbursement rules). Moreover, there are over 400 million dollars worth of approved projects waiting to be financed in order for construction to begin. If all of these projects were completed by 1987, the rate of increase between 1983 and 1987 would be approximately 70 percent, or 17.5 percent per year, without any new approvals.

The surge in capital spending in New Jersey furnishes a particularly disturbing example of the power of perverse financial incentives: Since the implementation of prospective payment for operating costs in 1980, the system has gone from under-capacity to over-capacity - a decline in occupancy of approximately 20%. Indeed, in a memorandum issued by Commissioner J. Richard Goldstein on February 11, 1986, the Department of Health estimates that excess capacity statewide may range between 5,000 and 9,000 beds out of 28,000 existing beds, by 1990. These conditions notwithstanding, the memorandum goes on the point out that '[c]oncurrently, in 1986 we are faced with a new wave of proposed capital projects which may exceed $600 million in total construction costs,' noting further that because of the capital pass-through, '...an unintended incentive for hospitals has been created to increase and maximize capital spending.' Not unexpectedly, New Jersey has imposed a moratorium on new capital expenditures. In a nutshell, the experience in New Jersey suggests that the failure to include capital in the prospective payment framework can produce potentially unnecessary capital investment of a significant level, in spite of declining utilization resulting from prospective payment for operating costs, comprehensive centralized planning, and so forth. Among other things, the Governor's Advisory Committee recommended in the area of reimbursement reform:

> that all (hospital) capital expenses be reimbursed through a prospective payment system. After a transition period, hospitals (would) receive a fixed price for each DRG which will include a component for capital. The capital component should cover all of the hospital's capital costs, including debt service and depreciation.

Incorporating capital into PPS through a DRG-specific add-on will create a direct linkage between real market forces and financial health. As we noted, "...Removing the artificial distinction between capital and non-capital inputs will make the rate structure more internally consistent, thereby encouraging hospital managers to consider the full range of potential operational trade-offs. Incorporating a capital component into prospectively determined rates will also give hospitals the incentive to make capital investment decisions which are more sensitive to real market conditions, for example: deferring new construction when interest rates are high; substituting more cost effective alternatives such as modernization, or; eliminating unneeded projects altogether. Perhaps most important, linking capital to real volume creates the financial pre-conditions to eliminate unneeded or inefficient facilities. Within a financial environment marked by 'scarce resources', devoting capital resources to unneeded or inefficient facilities can only compromise the financial health of the facilities which are needed and efficient. Conversely, promoting the financial health of needed and efficient facilities will occur naturally under a prospective capital payment system sensitive to both volume and patient case-mix."

Planning agencies will no longer need to monitor investment in equipment; since equipment will be incorporated into the rate per case, there are natural incentives for management to behave in a prudent business fashion. Planning agencies will no longer need to monitor investment in plant; assuming the cost pass-through is eliminated, even if management acts imprudently, cautious market forces will automatically temper the over-optimism which supports unrealistic volume projections. Rather than duplicate these financial incentives, thereby leading to potentially inconsistent investment results, planning agencies should seek to fully understand the imperatives of prospective payment, to let the natural incentives work without interference, and to complement the financial framework. For example, such agencies might collect information on a regional basis in order to assist the public, hospital management and the financial markets to make proper decisions. Even though theoretical, a periodic inventory of the plans of all of the providers in a region might be helpful in assessing new investment.

A residual role for planning agencies involves assuring "access": As providers make investment decisions in a manner consistent with the financial incentives of PPS, some areas such as inner-cities may be left underserved. Such changes must be carefully monitored and attention focused on these problems. Nevertheless, simply defining "access" as a planning issue would leave these agencies vulnerable to the same charge of ineffectiveness which was directed at them previously. Access is essentially a financing problem; if the money is there, the care will be provided. Accordingly, much like the information function described above, the main objective of the agency would be refocused on developing those data sets which are most helpful, and providing this information to financing sources in a timely way. In summary, therefore, we suggest that planning agencies avoid intervening where PPS provides natural financial incentives. Rather, consistent with the "Quayle/Durenberger" proposal, we believe that planning agencies should seek to complement

Ms. Shannon Salmon
Page Nine
April 8, 1986

PPS by developing information helpful to the public, the industry, and the financial markets, and by focusing on those areas, such as deteriorating access, where PPS has no effect.

Very truly yours,

Michael J. Kalison

Michael J. Kalison, Esq.
MANGER, KALISON, MURPHY & McBRIDE

Richard Averill

Richard J. Averill
Vice President, Product Development
HEALTH SYSTEMS INTERNATIONAL

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals and Clinics
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

April 7, 1986

Mr. Edmund J. Mihalski, C.P.A.
Deputy Chief of Staff
for Health Policy
United States Senate
Committee on Finance
Washington, D.C. 20510

Dear Mr. Mihalski:

Enclosed please find the responses to the questions of Senators Packwood and Durenberger that you requested in your March 20, 1986 correspondence.

If you or they should have further questions please contact me at your convenience.

Respectfully,

C. Edward Schwartz

C. Edward Schwartz
Hospital Director

CES:atn

HEALTH SCIENCES

Question for C. Edward Schwartz from Senator Durenberger

1. You state in your written testimony that the capital payment methodology used in S. 2121 does not recognize the above average capital costs of tertiary care teaching hospitals. But, in S. 2121, the Federal portion of the national capital payment amount is multiplied by the indirect teaching adjustment factor. Isn't this, in fact, an adjustment for the above average capital costs of tertiary care teaching hospitals?
(C0426)

S. 2121 adjusts the Federal portion of the national payment with an appropriate weighting factor. No specific mention of an indirect medical education adjustment is made within S. 2121. If the term appropriate weighting factor is defined as case mix and indirect medical education then the formula proposed under S. 2121 would include an adjustment for the extraordinary costs of teaching facilities. The language of S. 2121 should specifically define what is meant by an appropriate weighting factor so that the indirect medical education adjustment is not omitted when S. 2121 is implemented.

Question for Mr. Schwartz from Senator Packwood

1. In your statement you call for a "fair transition" given financial pressures arising from reductions in support for graduate medical education, impending tax law changes, and the growth of alternative delivery systems.

   What number of years represents a "fair transition"?

   (C0426)

When considering a major change in the way Medicare pays for capital costs, it must be recognized that each hospital has its own unique capital cycle. Some have new plants with high construction and financing costs, while others have older plants with lower costs and some of these may need to be replaced. Capital costs, particularly those associated with buildings, are long term in nature, e.g., 30 to 40 years. Acquiring the funds to rebuild facilities most often requires large amounts of debt financing. Most long term financing is done over a 25 year to 30 year life cycle and most of these financings have expensive prepayment penalties where optional redemption occurs within 10 years of issuance.

In order to provide a fair and equitable transition from a cost reimbursement system to a prospective payment system the following principles should be considered:

a. The transition mechanism should be structured to recognize the needs of individual hospitals which have recently incurred long term obligations for debt payment. The cost base for the transition should include all capital expenditures by hospitals which have been committed prior to the transition period.

b. The transition period should be of adequate length to allow hospitals the opportunity to restructure their debt without having to pay large premium penalties to accomplish the refinancing. In today's financial market, we believe that a 12 to 15 year transition would provide this opportunity.

Absent a fair and reasonable transition period many hospitals, particularly those which have recently taken on large amounts of debt, will be unable to meet their debt service payments and provide access to funds for future capital requirements.

AMERICAN HEALTH PLANNING ASSOCIATION

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Treasurer
Shirley H. Wester, M.P.H.
Executive Director

April 10, 1986

Senator Durenberger
U.S. Senate
Washington, D.C.

Dear Senator Durenberger:

Thank you for the opportunity to testify on March 14 concerning Medicare capital payment policy and to respond to additional questions. Although we advocate a position different from your legislative proposal, we strongly commend you for attempting to move towards a more equitable solution than the simplistic and regulatory approach of the administration. In addition we very much appreciate your continuing efforts to enact a new and streamlined system for health planning.

Attached are our responses to the questions posed in Mr. Mihalski's letter of March 20, 1986.

Sincerely,

David Abernethy
President-Elect
American Health Planning Association

AHPA/VA Conference—Systems Integration: Compounding The Cubes—Hyatt Regency Baltimore and Sheraton Inner Harbor Hotels—Baltimore, Maryland—December 15-18, 1985
6th Annual Health Policy Conference—The Washington Hilton Hotel—Washington, D.C.—March 4-6, 1986
16th Annual Meeting—Hyatt Regency San Francisco at Embarcadero Center—San Francisco, California—June 30-July 2, 1986
1110 Vermont Avenue, N.W. • Suite 950 • Washington, D.C. 20005 • (202) 861-1200

QUESTION #1

You urge Congress to develop a capital policy which incorporates eight principles. Today we are reviewing two proposals to reform capital payments. How would you evaluate each proposal in light of the eight principles you espouse?

ANSWER

Unfortunately, neither the administration's capital proposal nor Senator Durenberger's S.2121 address the issues raised by AHPA's eight principles. To a large extent that is because the two capital proposals considered by the Subcommittee have much more limited objectives those than embodied by our principles. It appears the proposals considered are intended to promote institutional efficiency with respect to capital expenditures within a predictable level of federal spending. In the administration's proposal, the level of federal spending is not only predictable, but also inadequate. AHPA's principles, on the other hand, were designed to ensure targeting of limited dollars to needed institutions to improve systemwide, as opposed to just individual institution, efficiency and equity.

We remain convinced that a broader policy is in the best interest of the Medicare beneficiary and that the effect on access to services by Medicare beneficiaries should be paramount in any policy. Polices which will underpay some needed institutions and provide windfalls to other institutions should be avoided even if they are predictable and easier to administer.

The administration's proposal should be rejected in its entirety. It is inadequate to meet the capital needs of the health care system as a whole and will have an arbitrary and negative impact on individual institutions.

Senator Durenberger's proposal, which has a more reasonable transition period and more adequate payment levels, could be modified to avoid potential disruption in the flow of capital to needed hospitals and services. Specifically, we suggest the following modifications to improve access and avoid undesirable consequences:

1. Given the significant variance between hospitals our testimony references, there should be incorporated an outlier policy, within budget neutrality limits, for the payments associated with both high and low capital ratio hospitals. The distribution of outlier payments should be based upon state determinations of needed institutions with legitimate capital needs. Federal support should be provided to states for this purpose.

2. Any policy to incorporate capital into the DRG rates must, at a minimum, grant states the flexibility to obtain waivers to allocate capital more effectively to needed institutions.

3. S.2121 should be amended to allow for the continuation of Section 1122 capital expenditure reviews and state certificate of need programs for non-DRG hospitals and services and for DRG hospitals during the transition to national rates.

Finally, we implore Congress to maintain federal support for the many non-regulatory functions health planning agencies can and do play in a prospective payment system. Many of these non-regulatory functions are critical regardless of the capital policy enacted by the Congress. The ability of communities to analyze changes in services and access and to inform purchasers and citizens of the availability of cost effective delivery alternatives is an essential service that health planning agencies must continue to provide as the new capital payment policy is implemented.

QUESTION #2

What advantages do proposals to pool capital reimbursement or to establish limits on capital have over the two under review today?

ANSWER

Proposals to limit or pool capital payments have the following advantages over the two proposals considered on March 14, 1986:

- The allocation of capital within limits allows targeting of limited Medicare dollars to needed institutions and services.

- They make capital decisions responsive to the health care needs of the community, as opposed to the institutional need to market for patient shares.

- They negate the need for a lengthy or costly transition to accommodate legitimate variations in hospital capital ratios.

- They provide a mechanism for shrinking a health care system which is overcapitalized, while ensuring capital to needed institutions which are undercapitalized.

- They remove any incentive for institutions to increase volume in order to increase capital payments.

- They force collaborative efforts between institutions which would otherwise duplicate expenditures in competitive efforts to obtain market shares.

- They will allow states to act as allocators of capital in the best interest of the public.

- They reduce the cost of capital by reducing risk.

- They allow hospitals, which may not otherwise be in an equal position to access capital, to compete fairly and publicly for limited capital.

- They can be budget neutral, without disrupting needed services.

Blue Cross
and
Blue Shield
Association

1709 New York Avenue, N.W.
Washington, D.C. 20006
202/783-6222

April 10, 1986

United States Senate
Committee on Finance
Attention: Shannon Salmon
Washington, D.C. 20510

Dear Ms. Salmon:

This is to respond for the record to Senators Packwood and Durenberger's questions submitted in reponse to our March 14, 1986 testimony on Reform of Medicare Reimbursement for Capital Expenses.

Please contact me if we may provide any additional information on this issue.

Sincerely yours,

Alan

Alan P. Spielman
Executive Washington Representative

APS:am

Enclosure

Blue Cross and Blue Shield Association
Response to Senator Packwood's Questions
Submitted for the Record for
the Senate Finance Health Subcommittee
Hearing on Reform of Medicare Reimbursement
for Capital Expenses
March 14, 1986

Senator Packwood: Please elaborate on your comment that hospital investment in capital is an essential element in producing quality care.

Response: Investment in capital by the hospital industry is used primarily to construct or renovate physical plant and to purchase equipment and technology. Other significant uses of capital include 1) changes in patient care services, e.g. shifting emphasis to ambulatory services, 2) refinancing of debt, and 3) acquisition of hospitals by multi-hospital organizations.

In the hospital industry, acquisition of fixed assets - land, building, and fixed and movable equipment - represents the largest portion of capital expenditures. these expenditures maintain overall operating standards and meet patient demand (volume and services). An adequate and continuing infusion of revenue is needed by existing hospitals to replace or renovate outdated facilities, to respond to changing demand by changing plant or services and adding new technology, and to increase labor productivity.

In particular, rapidly occurring advances in technology which contribute to improved patient care are often embodied in major pieces of equipment. Consequently, capital expenditures play a significant role in both the cost and quality of hospital care. Therefore, changes in the capital payment policies of major purchasers of hospital services (e.g., the Medicare program) can greatly affect these important dimensions of hospital care.

Senator Durenberger: How should "windfall" profits be treated for hospitals that currently are below the national average in capital expenses?

Response: The term "windfall" refers to sudden or unexpected financial gain. In the context of Medicare capital payment policy, it refers to the additional payments that would be received by some hospitals under DRG rates that include amounts for capital expenses, relative to the payments those hospitals would have received under cost reimbursement. The hospitals that would reap benefits are those that have per case capital expenses below the national average, e.g. many small, rural hospitals and urban, public hospitals. The length of the transition period and the year-to-year blending proportions of the hospital-specific and federal components of the rate directly affect the level of and rapidity with which those hospitals would receive additional capital-related payments.

In relative terms, a longer transition that places greater emphasis on hospital-specific weighting of the blended rate provides more gradual increases in payments to such hospitals than does either a shorter transition and/or one with lesser weighting of the hospital-specific component.

In our view, the primary purpose of a transition period is to minimize any adverse financial impact upon highly leveraged hospitals as the revised payment policy is implemented. We support the concept of a longer transition period and greater weighting of the hospital-specific component as reflected in S. 2121 because it will permit highly leveraged hospitals a more reasonable opportunity to adapt to the changing payment levels. Correspondingly, this approach also assures that hospitals with capital costs below the average will not receive "windfall" profits, but rather a moderate, phased infusion of additional capital-related payments.

Senator Durenberger: If a hospital has a capital debt stretching out for 30 years, is a four year transition period with a straight line phase-out of the hospital-specific portion sufficient for such a hospital to meet its debt obligations?

Response: The question of the appropriate length and design of the Medicare capital payment transition should not be linked to hospital's debt repayment obligations, for the following reasons: Major capital investments by hospitals are generally financed primarily through long-term debt instruments (about 15 to 30 years) which spread the expense out over a long term, with predictable principal and interest payments on an annualized basis. This expense, in aggregate, raises the overall underlying operating cost of the hospital. Therefore, prudent hospital managers do not undertake such investments unless aggregate revenues from all sources are projected to meet or exceed aggregate operating expenses, including capital debt obligations, within a reasonable period of time.

Separately, it should be understood that cost-based payments under the current system do not relate directly to the amounts needed by a hospital to meet its capital debt obligations. Rather, the Medicare program has historically paid hospitals amounts that are linked to the "use" of capital assets in the provision of patient care. These amounts are founded on the acquisition cost of the capital assets, and includes interest expense if acquisition of the asset was financed through debt. The primary Medicare capital payment is depreciation. Depreciation accounting is simply a technique for allocating the acquisition cost of a capital asset to operating costs (to reflect its employment in patient care) on an annual basis over the useful life of the asset. It bears no relation to how the asset was financed. In fact, repayment of the principal on debt has never been recognized as a reimbursable cost under the Medicare program. For major capital assets, such as physical plant, hospitals often finance the acquisition cost through debt payable over much shorter periods than an asset's useful life (for example, a building with a depreciable useful life of 35 years might be financed via a 20 year bond offering).

A hospital that has recently undertaken a major capital investment is likely to experience a reduction in Medicare's capital-related payments as the transition progresses toward national average rates. Therefore, in such cases, the more relevant question is what constitutes a reasonable period in which highly leveraged hospitals could adjust to potentially reduced Medicare capital-related payments?

Historically-based analyses of changes in hospitals' capital to operating expense ratios indicate that it may be several years after a major investment before such hospitals' relative capital expenses approach industry norms.

This suggests that a four-year transition is not adequate to enable such hospitals to adapt to reduced capital expense-related cash-flow by developing alternative sources of revenue or by other means. The straight-line phase-out of the hospital-specific component, relative to preferential weighting, further reduces payments to this class of hospitals thereby increasing the potential for financial disruption due to overly abrupt reductions in anticipated revenues.

Senator Durenberger: What is the advantage of using an all-inclusive payment amount rather than a percentage add-on?

Response: Integrating an average payment amount for capital directly into the standardized amounts that are the basis for DRG payments establishes a Medicare system that does not distinguish between payments for operating or capital costs. This has been referred to as the "total revenue" concept. By contrast, a percentage add-on approach perpetuates a distinguishable payment amount attributable to capital.

The total revenue approach is preferable for several reasons. Conceptually, it is important to focus attention on total revenue from medicare for inpatient hospital services rather than on payments for any single element of cost. Continuing to separately identify a percentage payment level for capital will trigger debate on the appropriateness and adequacy of that percentage regardless of the level chosen. In our view, the more important issue is the adequacy of aggregate Medicare payments to hospitals. Separately, focusing on aggregate payments (and expenses) is consistent with the way hospitals assess and manage their internal operations from a business standpoint.

For the purpose of Medicare program administration, the total revenue approach unifies the rate structure. In future years, subsequent to a capital payment transition period, a unified rate approach would simplify matters such as application of updating factors, Part A claims payment calculations, and if necessary, rebasing of the standardized payment amounts.

Senator Durenberger: Do you think that so-called "old" capital should be treated differently from "new" capital when developing a capital reform policy? If so, why? What are the advantages and disadvantages of such an approach?

Response: In general, proposals to treat old and new capital differently would continue hospital-specific payments for old capital until the assets are fully depreciated or removed from use, while gradually introducing an average amount for new capital to DRG-based prospective payments. This can be viewed as a "hold-harmless" transition option for existing capital.

This approach poses conceptual and technical difficulties. In a deficit reduction environment, payments under a revised capital policy are likely at best to be held to budget neutrality in aggregate, relative to projections of what cost-based capital expenditures would have been in future periods. In order to assure budget neutrality while protecting cost-based payments for old capital, only a negligible amount for new capital could be introduced into the DRG-based prospective payments. In effect, what many would argue is a poor distribution of capital payments under cost reimbursement would persist for some period of time. The primary beneficiaries of the old/new proposal are the relatively small number of hospitals that are currently highly leveaged with respect to capital investment. Not only would their current investment be protected for its entire useful life (up to 35 years for some assets), but they would also receive the additional (albeit small) amounts for new capital. In contrast, a large number of hospitals with aged physical plants and already depreciated assets, such as many urban, public hospitals, would continue to be disadvantaged by the very low cost-based payments for old capital and negligible amounts for new capital.

Separately, this proposal would maintain a fragmented Medicare payment capital policy for a long time, thereby delaying many of the advantages of incorporating capital payments into the prospective payment system. It could be complex to administer from the standpoint of continued record keeping and monitoring to assure termination of payments when "old" assets are depreciated, sold or otherwise disposed of.

On the other hand, one advantage of the old/new transition option is that it prevents any financial disruption to hospitals that have recently under taken major capital investment. As we indicated in our testimony, we believe the primary purpose of a transition period is to ameliorate financial disruption to hospitals that are highly leveraged at its inception. However, we believe the transition approach outlined in S. 2121 accomplishes that goal in a manner more consistent with the prospective payment system.

Senator Durenberger: Blue Cross and Blue Shield believes four principles should guide the development of reform proposals. One of the principles is an adjustment process for exceptional circumstances. When might there be a need to adjust for an exceptional circumstance?

Response: The major circumstance that might support special treatment for reimbursement purposes is the establishment of a new or replacement hospital, or the renovation of an existing one where the renovation is so extensive that it is virtually a new facility. For several years subsequent to the opening of a new hospital or the major renovation of an existing one, the capital to operating expense ratio of the hospital is considerably above the national averages that would be implicit in the DRG-based prospective payment rates. Further, under DRG-based capital payments, revenue to the hospital is linked directly to the volume of admissions. New hospitals, in particular, often require a period of three to five years to achieve a reasonable occupancy level. The combined effect of these is such that these hospitals would receive the lowest capital-related revenues at a point when their capital financing expenses consume the largest portion of their overall operating expenses.

AARP

TESTIMONY SUBMITTED FOR THE RECORD BY THE

AMERICAN ASSOCIATION OF RETIRED PERSONS

SENATE FINANCE COMMITTEE

SUBCOMMITTEE ON HEALTH

CAPITAL PAYMENTS TO HOSPITALS

March 27, 1986

American Association of Retired Persons 1909 K Street, N.W., Washington, D.C. 20049 (202) 872-4700
Vita R. Ostrander *President* Cyril F. Brickfield *Executive Director*

EXECUTIVE SUMMARY

The American Association of Retired Persons believes that major capital issues confronting the hospital industry today are excess capacity and maldistribution of resources.

Policy regarding Medicare payments for capital must reflect these realities. Current proposals to change our capital payment methods should be evaluated in terms of the policy's impact on system-wide health costs, access to care, and the quality of services provided. These system-wide concerns should override the particular interests of hospitals.

One way to rationally allocate capital funds is to pool them and then distribute money on the basis of objective and fair criteria of community need. AARP recommends that Congress seriously consider this approach.

Proposals to include capital payments into the prospective payment system would, during the transition period, reward recently recapitalized hospitals and would not further the goals of managed capacity reduction and targeting of funds to hospitals most in need of capital improvements. Nor would these proposals foster community involvement in planning their health resources.

AARP urges Congress to enact legislation embodying these policy goals.

The American Association of Retired Persons, with its 22 million members age 50 and older, welcomes the opportunity to comment on various proposals on capital payments to hospitals under Medicare.

Needed Policy Goals

In our view, the major issue before us today is not the lack of hospital capital, but rather excess capacity and maldistribution of fixed and movable capital resources. One very promising solution would be to pool capital by state or region and then allocate funds according to agreed upon guidelines.

While AARP does not presently endorse any specific method for computing Medicare payments to hospitals for fixed and movable capital, we strongly believe that any capital payment policy should be scrutinized in terms of its impact on overall health care costs, access to care by all persons in need of hospital services, and the quality of care available.

Although we believe that hospital managers need stable and predictable revenue sources for purposes of planning and that a degree of managerial automony is necessary and proper, the government has a legitimate interest in promoting cost containment and assuring access to quality care. That is, system-wide concerns should supercede the particular concerns of specific institutions for the good of all.

In addition to these broad concerns, we believe that any proposed capital policy should be evaluated in terms of the following questions:

- How will capital payment policy affect growing excess bed capacity, which helps drive up costs system-wide? According to figures recently cited by the American Hospital Association, national bed-occupancy rates hover around 66% and will dip even lower. We are all paying for those empty beds. Will the capital payment policy help target and manage shrinkage of hospital capacity?

- Will capital payments be targeted to institutions and areas most in need of expansion or capital improvement? That is, will proposed policies ensure that persons in medically underserved areas will be provided access to needed care? Will adequate funds go to deteriorating inner-city hospitals that provide a disproportionate share of service to indigents, the uninsured, and Medicare beneficiaries?

- How will capital policy affect the acquisition of medical technology? Experts estimate that medical technology contributes between 30% and 50% of annual growth in health care costs. We need to provide incentives for the acquisition and appropriate use of technology that is cost-effective. Acquisition decisions should be based on a reasoned and impartial determination of community need. It should not simply reflect the availability of capital or be based on a hospital marketing strategy.

- Are data collection and evaluation required components of the payment policy?

The Administration's Proposals:

In FY 1987, the Administration proposes to begin including capital costs into the prospective payment system (PPS). Over the four-year transition period, standardized payment amounts for rural and urban hospitals would be built into the non-labor component of DRGs. By 1991, an all-inclusive payment rate would be linked with the volume of Medicare discharges. Payments for depreciation, return on equity, and interest will be phased out during the transition period, beginning October 1, 1986. This new payment method would be effected by means of regulation, rather than legislation.

Senate Bill S. 2121, the Fair Deal Capital Payment Act of 1980, co-sponsored by Senators Durenberger and Quayle:

Like the Administration's proposal, S. 2121 would phase in fixed capital payments based on the DRGs. However, this bill provides for a longer, seven year transition period during which time hospitals would be reimbursed for their capital costs including interest, rental, depreciation and return on equity. The transition formula would blend national and hospital-specific cost data, but the formula would reflect hospital-specific costs in the first years of the transition.

Additionally, S. 2121 would repeal Section 1122 of the Social Security Act, thereby eliminating the capital review process.

AARP's Reaction to the Administration's Proposal and S. 2121:

Without commenting on the technical aspects of the proposed payment methodologies, AARP notes that both options contain significant drawbacks. The primary flaw in linking fixed capital payments to DRGs is that it would not accurately reflect either institutional or community-wide need for capital.

Under both of the proposed formulas, the money would flow to over-capitalized hospitals, those in need of expansion and improvement, as well as those with recently acquired high capital costs. During the transition period, the formula would reward recently recapitalized hospitals whether or not the investment served community interests. And it would penalize those hospitals which did not recently make capital improvements. The transition formula would simply reward hospitals with high debt burdens. Specifically, hospitals that are: proprietary, have high daily expenses with relatively low occupancy rates, southern, and with relatively low volumes of Medicaid admissions would, during the transition, receive more money than high occupancy urban community hospitals despite the fact that the latter are in great need of capital improvement.

Nor for that matter does the formula reflect or provide for any assessment of community-wide needs to expand, contract, or target capacity and/or reduce costs. The Administration's explicit goal is to phase out health planning processes which we believe are needed.

By folding capital payments into the DRG system, hospitals can maximize payments through admission and diagnosis decisions while avoiding system-wide planning and community review. As we understand the Administration's proposal, only PPS-exempt hospitals would continue to be subject to Section 1122 authority.

AARP believes that capital decisions should be subject to external review because capital assets generate operating costs in excess of the cost of the asset and because acquired assets tend to be used, further driving up system-wide costs. Yet the proposed formula would seem to concentrate decision-making in the individual hospital to the exclusion of other interested parties, such as health planning agencies and consumers.

Furthermore, the proposed capital formulas are insensitive to measures of service to indigents and community need. It is conceivable that higher capital payments would go to hospitals located in areas with excess capacity. We believe community service and need must be factored into capital payment systems. While community hospitals may end up receiving higher capital payments under a national rate than they currently receive, the additional amount may simply be used to subsidize uncompensated care rather than to acquire capital improvements. Without data showing the impact of specific formulae on different types of hospitals, it is difficult for AARP to evaluate the proposals put forth.

Under a fixed payment formula, hospitals would have an incentive to acquire capital that would help increase admissions.

Another unintended consequence of fixed capital payments may be to stimulate cost-shifting among payers in unregulated states. This, in our view, is both undesirable and inequitable.

It is difficult, absent data, to assess the impact of the various phase-in proposals. Although hospitals have been on alert since 1983 that reimbursement mechanisms would change, hospital bond sales surged from $8.5 billion in 1984 to $22 billion in 1985. The longer the phase-in period, the greater the reward will be for heavily capitalized hospitals. Is such a reward in the public interest? We don't know.

For these reasons, AARP believes that more information about the effect of the proposed formulae is needed before we can judge them to be in the nation's interest. However, we do believe that this issue is too important to be left to regulation. We believe that legislation is the appropriate vehicle because it provides for greater participation by interested parties. For that reason, we urge Congress to substitute its judgement for the regulatory approach advocated by the Administration.

As stated above, we believe that capital issues should be subjected to a broad planning process. Scarce resources should be allocated rationally in a situation of excess capacity and maldistribution.

We urge Congress to seriously consider alternatives to fixed capital payments to individual hospitals. One option that merits further attention is some form of capital pooling. Pooled funds should then be allocated on the basis of community-wide criteria including need, access to care, quality of care, and cost containment. We would be happy to work with the Congress to develop alternative approaches to Medicare capital payments.

STATEMENT OF THE
AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION
BEFORE THE
SENATE FINANCE SUBCOMMITTEE ON HEALTH
ON
PROPOSALS TO REFORM MEDICARE PAYMENT FOR CAPITAL COSTS
MARCH 14, 1986

Introduction

The American Osteopathic Hospital Association (AOHA), the national organization representing the more than 200 osteopathic hospitals in the United States, is pleased to present our policy position on reforming Medicare payment for capital costs.

Osteopathic Hospital Profile

Osteopathic hospitals are acute care community hospitals that provide the proper medical environment for the practice of osteopathic medicine - the only accepted comprehensive alternat to traditional medicine. Our institutions are located in 29 states with the majority centered in Michigan, Missouri, Pennsylvania, Texas, Ohio and Florida. Many of our hospitals located in rural and semirural areas although osteopathic institutions are found in many of the major urban industrial centers. Osteopathic hospitals are generally smaller than competing institutions. Nearly half have less than 100 beds an over 80% less than 200 beds. All of our community hospitals wit 200 - 299 beds are teaching institutions, while 70% with 100 - 1 beds have teaching programs. The majority of osteopathic hospitals are non profit community institutions although a distinct minority are investor owned. Systemization is also evident in the osteopathic hospital environment. Thirty one multi-hospital organizations - both non profit and investor owned - own or manage osteopathic institutions.

Osteopathic Hospitals and Capital Policy

In 1984, AOHA endorsed incorporating capital costs into the Medicare prospective payment system but not before the October 1, 1986 legislative deadline. The Association recognized the need to have a consistent payment methodology and set of incentives for both operating and capital expenses. This does not mean, however, that a capital methodology should mirror the prospective payment system in terms of transition to a national program.

AOHA quickly identified access to capital as one of the most critical issues that osteopathic hospitals face in the future. With the typical osteopathic hospitals in a highly competitive local environment and generally being smaller than its neighboring allopathic institutions, equal access to capital is imperative fo the survival of the "osteopathic system".

In early 1984, the Association appointed a Task Force on Capit to develop an association capital plan. Its recommendations were eventually adopted by the Association as policy.

AOHA's policy is predicated on a set of characteristics that we feel should govern any capital plan. These include: recognition of existing capital assets on a hospital specific basis; treatment of existing and future capital assets separately; budget neutrality; an adequate phase-in period; a phasing-out of reporting overtime; and a program that is predictable, equitable, practical and feasible for all hospitals. Moreover, policy needs to provide some assurance that osteopathic hospitals will have access to capital in the years ahead. The Association accepts the premise that many osteopathic hospitals may have difficulty surviving as free-standing institutions in the future and that networking among facilities is the likely outgrowth. A capital policy should reflect this configuration while still respecting the needs of the independent osteopathic hospital.

AOHA's Proposal on the Treatment of Capital Costs

The AOHA policy is rooted on the assumption that the federal government has an obligation to protect and recognize each hospital's existing capital commitments. This is because all capital projects were approved over the years in accordance wit certificate-of-need and other federally approved programs. Wher hospitals made these commitments it was done in good faith.

Fairness and equity requires that such obligations be fully recognized as part of that compact. By basing payment for long term past obligations under Medicare on an "average" is unfair to both hospitals with heavy capital loads and those who have costs below the "average". Hospitals would be penalized or benefit from a timing decision based on a prior set of circumstances and policies.

Treatment of Existing Capital

We endorse hospitals receiving full payment for all existing assets for at least a 10 year transition period. This represents the actual depreciation of assets and other capital costs on the balance sheet of each hospital on October 1, 1986. During the transition period payments for existing assets would gradually decrease.

Capital obligated after October 1, 1986 should be treated differently. Payment should be independent of existing capital obligations of individual hospitals and be based on an avera capital commitments of hospitals nationally. The setting of add-on for new assets would be driven by the "budget neutral concept.

Treatment of Future Capital

The add-on for future capital should be set so when applied against total national expenditures, it would approximate what the federal government would have recognized if the system had remained the same.

Transition to All Inclusive Capital Add-on

As Medicare payments for prior obligations gradually fall over the time of the transition, the nationally based add-on for future obligations concurrently increases. An all inclusive nationally based rate for capital costs will result at the transition's conclusion. The length of the transition is fair since the average length of capital commitments is 25-30 years.

Administration Proposal

The Administration's proposal fails to reflect any of the characteristics of a fair capital plan advocated by AOHA. We oppose any plan that is promulgated through administrative fia We disagree with the Administration that Congress offered the Secretary latitude to include capital in the prospective payme rates through regulation. We encourage your efforts to enact capital plan through legislation.

The HHS plan is an attempt to implement federal budget policy through the mask of payment reform. One way the draft plan embodies this is through the caps it imposes on the hospital-specific portion of the payment. It is clearly not budget neutral reform but rather represents another attempt to reduce federal payments without congressional approval. By excluding legitimate factors such as return on equity and interest on funded depreciation, the proposal sets an artificially low base. This is compounded by the use of 1983 costs as the base which fails to consider the changing costs of capital over time. We see the HHS plan as seriously flawed and urge the Subcommittee to reject it.

Fair Deal Capital Payment Act (S.2121)

We commend you for your leadership in developing S.2121 and your earlier bill, S.1559. In addition, we support your call for emergency legislation to prevent implementation of the HHS regulations.

We agree wholeheartedly that the prospective payment system represents a deal between the federal government and hospitals. This deal has been severely shaken through budgetary policies that do not reflect the understanding hospitals had when they endorse the reform. We fear that capital obligations, committed to in full compliance with policies and procedures, will be subject to the same revisionist policies. We appreciate your sensitivity to this matter.

Your bill is an improvement over the HHS plan. The transition is longer; weighs heavier on the hospital-specific side; uses the most current capital expense information for the federal base; uses a marketbasket of Medicare capital spending as a way to update payments; and is more budget neutral than the Administration's draft. These are substantial improvements.

Where we differ is the use of the Administration's model as the starting point to make appropriate refinements. Our proposal recognizes the government's obligation to honor its commitments. Over time, as the value of a hospital's capital assets diminish, the federal government's financial obligation will lessen. The corresponding federal rate will increase until the two merge at the conclusion of the transition. We would ask you to consider extending the transition and not eliminating return on equity or the interest on funded depreciation. We agree that the latter t payments have a grounding in policy as you stated upon introducing S.2121.

We feel your bill is a better deal for hospitals than the HHS plan. However, it is our belief that a mechanism that distinguishes between existing capital assets and future capital assets is inherently fairer.

Thank you for the opportunity to present our views on capital reform.

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Charles D. Phillips, Ed.D.
President

STATEMENT
OF THE
AMERICAN PROTESTANT HEALTH ASSOCIATION
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON FINANCE
UNITED STATES SENATE

MARCH 14, 1986

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A. Summary.

1. Legislation Not Regulation.

The Administration's proposal for capital reimbursement is designed solely to achieve short-term budget reductions and bears no relationship to rational and sound health policy. Any changes made in capital reimbursement policy should be made by the Congress through legislation rather than by the Secretary of Health and Human Services through regulation.

2. One Year Delay.

The Congress should delay any change in Medicare capital reimbursement policy for one year to assess the impact on hospitals of other factors affecting capital financing, such as tax-exempt bond financing and frozen Medicare operating revenues.

3. Application To New Capital Only.

Any new capital reimbursement methodology should apply only to new capital. Old capital should be "grandfathered." Old capital is defined as that obligated (as defined by the Section 1122 regulations at 42 C.F.R. §100.103(c)) prior to April 20, 1983, and for which financing has been completed by October 1, 1986.

4. Necessary Components Of Any New Methodology Where Old Capital Is Not "Grandfathered".

If the Congress should determine a comprehensive prospective capital policy, applying to old capital, three necessary components include: a minimum ten-year transition period; a weighted blend comprised of national and hospital-specific rates; and rolling bases for both national and hospital-specific base years.

5. Repeal Section 1122.

Section 1122 of the Social Security Act should be repealed.

B. Introduction.

The American Protestant Health Association (APHA) represents 300 hospitals and nursing homes in 39 states, totaling over 60,000 beds. On behalf of our nonprofit membership, we appreciate the opportunity to present our views in this format.

C. Discussion.

1. The Administration's Proposal Should Not Be Adopted And Congress Should Legislate Any New Capital Policy.

The Department of Health and Human Services ("HHS") proposes to restructure the existing system of Medicare capital cost reimbursement to hospitals through regulations. Capital costs are to be included in the Prospective Payment System ("PPS") of Medicare reimbursement beginning with cost accounting periods starting on or after October 1, 1986. The Department contemplates issuing a notice of proposed rulemaking as early as June 1, 1986.

The Administration proposes a national prospective payment for capital which would be phased-in over a four year transition period. During the transition period, payments to hospitals would be based on a combination of a national and hospital specific rate. The proposal implements a 1983 base year for the national rate and a 1986 base year for the hospital-specific rate. The Administration's proposal is not a sound health policy, but is, instead, based solely on short-term budget savings. It is seriously flawed and probably illegal. HHS is statutorily committed to reimburse capital projects on a reasonable cost basis for capital obligated before April 20, 1983, the date of enactment of the PPS program. The Conference Report to the Social Security Amendments of 1983 refers only to the possibility of changing the capital payment policy for capital obligated after April 20, 1983, and does not consider that capital obligated prior to that date would be subject to a new capital policy. See Conf. Rep. No. 98-47, 98th Cong., 1st Sess. 190 (1983). The Administration is seeking to implement a blended national and hospital-specific rate, which would be less than the hospitals' actual fixed capital expenses. Thus, the amount of capital reimbursement will not cover the hospitals' fixed debts, and many will be forced into default on their bonds.

Further, the Administration recommends using base years to determine the national and hospital-specific rates (1983 and 1986, respectively) which do not account for any capital expenditures obligated prior to April 20, 1983 and not yet on line until 1987 or later. Those costs would not have been reflected in the 1983 and 1986 cost reports and, therefore, are not recognized by the Administration's proposal.

The crucial health policy issues raised by the drastic cut in hospital capital resources flowing from this proposal require that policy be made by the Congress through legislation, and not by the Secretary through regulation.

2. Any Change In Medicare Capital Reimbursement Policy Should Be Delayed For One Year.

The Congress should assess the impact of other factors affecting hospitals' access to capital in order to execute an adequate and equitable capital reimbursement policy. One such factor is the tax-exempt bond legislation under consideration currently in the Senate Finance Committee as part of tax reform. The Tax Reform Act of 1985, H.R. 3838, would severely restrict hospitals' ability to finance new projects using low-interest capital and would limit the access of non-profit hospitals to the capital markets. Indeed, data from the New York State Medical Care Facility Finance Agency indicates that contemplated PPS reimbursement rates would result in an 80% default rate in FHA 242 mortgages. This would occur because capital reimbursement would be insufficient to amortize high interest mortgage loans.

Similarly, Medicare reimbursement for operating revenues has been essentially frozen for at least the next five years by the operation of Gramm-Rudman-Hollings.

Tax-exempt bond restrictions and reduced operating revenues will inevitably restrain the incursion of capital costs. This effect may obviate the need for the inclusion of capital costs in the PPS. At a minimum, the Congress should delay implementation of any new capital methodology for one year in order to evaluate the impact of tax reform and other related legislation upon hospital capital and operating resources.

3. Protection Of Old Capital.

The statutory provisions regarding reimbursement of capital are admittedly complex. The only reasonable construction of those provisions, however, indicates that all capital obligated prior to April 20, 1983 (the enactment of the PPS) is exempt from the PPS and should be reimbursed on a reasonable cost basis. See Section 1886(a)(4) of the Social Security Act (42 U.S.C. §1395ww(a)(4)). The intent of the Congress to reimburse capital obligated prior to April 20, 1983 on a reasonable cost basis is reaffirmed in the Conference Report to the Social Security Amendments. The Report states that there is no assurance that projects obligated after April 20, 1983 will continue to be paid on a reasonable cost basis. This indicates that capital obligated prior to that date will be reimbursed on a reasonable cost basis regardless of when those capital costs are paid. See Conf. Rep. No. 98-47, 98th Cong., 1st Sess. 190 (1983).

We propose a definition of old capital which would include capital obligated prior to April 20, 1983, and for which financing has been completed by October 1, 1986. Such a definition reflects a compromise and sets clear parameters for that capital which should properly be exempt from the PPS. Thus, we propose that old capital be "grandfathered" in a prospective capital payment policy.

In addition to the legal argument mentioned above to "grandfather" old capital, there are practical and policy considerations which should be considered. The nature of capital expenditures is very different from operating costs. Capital obligations are fixed, long-term costs, while operating expenses are flexible and can be reduced if necessary. Capital obligations made prior to April 20, 1983, for which financing has been completed by October 1, 1986, are fixed, long-term commitments. These costs cannot be reduced to enable hospitals to afford and accommodate reduced reimbursement rates. Instead, hospitals will be forced into default on their bonds. When these commitments were made, hospital trustees and administrators appropriately relied on the then-existing Medicare reimbursement policy to honor the Medicare portion of these debts. It would be manifestly inequitable if hospitals were denied the Medicare reimbursement obligated for these prior commitments.

4. Necessary Components Of Any New Capital Methodology, Where Old Capital Is Not "Grandfathered".

If the Congress should determine a comprehensive prospective capital policy applying to old capital, certain precepts must be included in order to provide a fair policy and ease the harsh impact of the new reimbursement methodology.

a. Transition.

If prospective payment rates for capital are established, a sufficient transition period must be utilized. We strongly object to the Administration's proposed transition period. Senator Durenberger's bill, S. 2121, lengthens the transition period, but it is still too short. An adequate transition period must necessarily extend for at least ten years. Significantly, an October 25, 1985 draft report to the Congress, prepared by HHS, acknowledged the need for church hospitals to have a ten year transition period. See Modified Recommendation to Incorporate Payments for Capital Into the Medicare Prospective Payment System, Department of Health and Human Services, p. 95 (October 25, 1985).

In ascertaining an appropriate transition rule, the structure of hospitals' capital costs must be fully understood and considered. Capital costs are long-term in nature and follow an extended cycle unique to each hospital. Generally, this capital cycle is 20 years, with a ten year mid-life. A transition period that is sympathetic to current hospital capital cycles would help ensure that hospital capital financing programs are not subject to serious disruption substantially jeopardizing a hospital's ability to make required capital improvements and to continue to provide high quality of care to Medicare beneficiaries.

b. Weighted Blend.

We consider S. 2121, introduced by Senators Durenberger and Quayle, to be a reasonable starting point for the debate on an appropriate capital policy. We clearly prefer a weighted hospital-specific and national rate blend during the transition period. We believe, however, that the seven-year transition to a national rate for capital costs, prescribed in the bill, is too short to provide hospitals with adequate protection. Thus, we recommend a transition period of at least ten years, comprised of a weighted hospital-specific and national blend.

c. Rolling Base.

It is the recommendation of APHA that no fixed base year be used, but that a rolling base of the prior year's cost report be implemented for both the hospital-specific and national rates. This will ensure that capital reimbursement will more accurately reflect current levels.

7. Section 1122 Should Be Repealed.

Absent legislation by the Congress, Section 1886(g)(1) of the Social Security Act will make Section 1122 of that Act mandatory. The mandatory Section 1122 would require states to review providers' capital expenditures. Section 1122 should be repealed. Such a Congressional mandate to the States to review hospitals' capital decisions is unworkable and anti-competitive. The marketplace should govern whether hospital facilities should be constructed or renovated.

If the Congress choses not to repeal the mandatory Section 1122 program, it should enact legislation to require that the Secretary receive notice of disapproval from a state before capital expenditures are disallowed. The States should not be forced to affirmatively recommend approval of a project, particularly since only 15 states currently have a Section 1122 mechanism to review capital expenditures (Arkansas, Delaware, Georgia, Idaho, Iowa, Kentucky, Louisiana, Maine, Minnesota, New Jersey, New Mexico, Oklahoma and West Virginia).

D. Conclusion.

APHA believes that capital payments must be adequate and equitable in order to prevent the disruption and potential collapse of hospitals and, thus, capital financing mechanisms.

The Administration's proposal is devoid of any health policy considerations, reflecting only the short-sighted objective of budget reductions. Accordingly, APHA proposes that the Congress immediately rescind the Administration's regulatory authority to implement a prospective capital methodology. Further, the Congress should delay any revision of Medicare's capital policy until October 1, 1987, to allow consideration of the impact on Medicare capital policy of any tax reform legislation and Gramm-Rudman-Hollings.

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CompCare
Comprehensive Care Corporation

TESTIMONY

OF

EDWARD J. CARELS, PH.D.
EXECUTIVE VICE PRESIDENT
COMPREHENSIVE CARE CORPORATION

BEFORE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON FINANCE
UNITED STATES SENATE

CONCERNING

CAPITAL-RELATED COSTS UNDER THE MEDICARE PROGRAM

ON

MARCH 14, 1986

"we care for people"
18551 Von Karman Avenue, Irvine, California 92714 (714) 851-2273

Mr. Chairman and members of the Committee:

Thank you for this opportunity to submit our response and recommendations regarding capital-related costs and incorporation of capital-related costs into the prospective payment system. Comprehensive Care Corporation is a national leader in behavioral medicine services, annually treating more than 50,000 individuals for chemical dependencies and psychiatric disorders.

We understand that the Administration proposed to reduce projected Medicare expenditures by some $4.7 billion in FY'87. While we are sympathetic to the Administration's commitment to reduce the federal deficit, we are deeply concerned about further reductions in Medicare payments to hospitals and physicians, along with increases in beneficiary premiums and deductibles.

One of the major proposals is to alter the current cost-based reimbursement system for capital expenses (which account for 7.4 percent of Medicare's payments to hospitals). The proposal would gradually incorporate Medicare payment of capital costs into PPS over the next four years through the mechanism of regulation. Beginning in FY'87, 20 percent of a capital payment would be based on a national rate, while the remaining 80 percent would be based on a hospital specific amount. The ratio would change, until by FY 1991, it would be 100 percent national rate. Payments for return on equity to proprietary hospitals and interest earned primarily by voluntary hospitals on funded depreciation would be phased out over the next three years beginning in FY 1987. We do not believe such major issues should be decided through regulation, but instead should be a matter of Congressional hearings, debate and voting. Additionally, any new capital payment plans should treat "existing" capital in a manner "similar to current law." Hospitals should not be penalized for capital expenditure decisions made in the past.

We oppose the elimination of the return on equity as an allowable cost for inpatient hospital services. In November of 1966, Congress added return on equity capital for proprietary providers to compensate investor-owned hospitals for economic costs of acquiring needed equity capital. For-profit hospitals have raised more than $2 billion in equity capital from outside investors. But those investors require a competitive rate of return. The ROE incentive becomes even more important during this time when public funding is not readily available. Additionally, elimination of the ROE would unfairly discriminate against investor-owned hospitals. Such investor-owned hospitals must pay taxes, cannot accept philanthropy and cannot issue tax-free debt except in highly limited circumstances; they are at a cost disadvantage relative to non-profit hospitals. Investor-owned hospitals have contributed immensely to this country in terms of new technology, greater access to care and operational efficiency. They deserve an equal opportunity to compete.

To help restore monies to Medicare, we urge that Congress consider raising the excise tax on beer and wine. The simplest way to increase taxes on beer and wine would be to equalize the tax rates for all alcoholic beverages. Adjusted for alcohol content, beer is currently taxed at one-fourth the rate of distilled spirits, and wine is taxed at one-seventeenth the rate. An increase in federal excise taxes could generate additional revenues of between $4.3 billion and $20.5 billion annually. Increased alcohol taxes would be user taxes, since 10 percent of all drinkers account for 50 percent of the alcohol consumed in the United States.

Mr. Chairman, thank you for the opportunity to present our views on capital related costs as they pertain to Medicare payments to hospitals.

Hospital Association
of New York State
of the Center for Health Initiatives

STATEMENT OF THE
HOSPITAL ASSOCIATION OF NEW YORK STATE

ON
EXAMINATION OF PROPOSALS
TO REFORM MEDICARE PAYMENT FOR CAPITAL COSTS

PREPARED FOR A
PUBLIC HEARING HELD BY

FINANCE COMMITTEE
SUBCOMMITTEE ON HEALTH

Washington, D.C.
March 14, 1986

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MEDICARE PAYMENT FOR HOSPITAL CAPITAL COSTS
SUMMARY OF KEY POINTS

The issue of incorporating Medicare capital expenditures into the prospective payment system (PPS) contains serious implications for hospitals and the patients they serve. In addition, the issue of Medicare's treatment of capital cannot be considered in isolation to the development of an overall capital strategy designed to maintain an adequate hospital system infrastructure. The Department of Health and Human Services' (HHS) failure to submit -- on a timely basis -- the Congressionally mandated report outlining the issues involved to serve as the basis of Congressional policy decisions dictates at least a one year delay in the incorporation of capital into PPS. HHS' decision to proceed with the incorporation of capital into PPS through regulation, and in the absence of statutory policy guidelines, is a violation of Congresses 1983 stated intent that such was to be accomplished by legislation. As such, there is a need for an immediate and explicit statutory pre-emption of Secretarial authority in this area.

I. Position of Hospital Association of New York State

Congress should pre-empt the Secretary's authority to impose a system incorporating capital payments into PPS through regulation.

Congress should postpone any decision to incorporate capital into the prospective payment system for at least one more year.

II. If Congress is unwilling to postpone action on this issue, then any capital reimbursement system Congress enacts must address several basic principles.

A. Must provide for an equitable return of capital and protect existing capital obligations

B. Must recognize differences between hospitals and between states

C. Must be by statute and not by regulation

D. Must address the needs of inner city hospitals

E. Must recognize that teaching hospitals in New York State are a national resource

F. Must address the unique problems of rural hospitals

III. If Congress is committed to a methodology that incorporates capital into the prospective payment system through some form of add-on, then that system should include the following elements:

	Title	Comments
A.	Effective Date and Authority	Congress should pre-empt the Secretary's authority to impose this system through regulation
		Must be by Statute; 10/1/87
B.	Dollar Impact	Must be Budget Neutral; i.e., no less than Medicare would pay systemwide under existing principles of capital cost reimbursement
C.	Federal Portion	The base must be the most recent 12 month period prior to the effective date of the new methodology
		Must impute a return on equity (ROE) for all facilities
		Must not include an interest offset
D.	Update Factor	Building & Fixed: Construction Cost Index
		Movable Equipment: Capital Equipment Index
E.	Regional Adjustment Factor	Must include a Regional Adjustment Factor
F.	Hospital Specific Portion (HSP)	Must be based on each year's capital costs
		No interest offsets
G.	Transition	Building & Fixed: 12 years
		Movable Equipment: 5 years
		Non-geometric; i.e., more heavily weighted towards hospital-specific costs during the early years. (Senator Durenberger's proposal is non-geometric)
H.	Indirect Education	The indirect medical education adjustment factor must be applied to capital costs

Title	Comments
I. Medicaid Reimbursement	Medicaid reimbursement for capital must be independent of Medicare payments; i.e., Medicare capital payment should not become the upper limit for state Medicaid capital payments
J. Certificate of Need (CON)	Must be accompanied by the repeal of Section 1122 Must prohibit state assessment of Medicare payments for hospital capital costs and the creation of state capital funding pools Continuation of the pass-through must be maintained for those projects which received approval from federally funded health planning agencies through certificate of need (CON) review on the basis of community need in states which link such approvals with reimbursement
K. Exceptions	Must include special adjustments for a. teaching hospitals b. facilities that recently completed or are in the midst of a construction project c. hospitals that provide care to the medically indigent (a disproportionate share adjustment) d. rural hospitals Must include a. Limited appeals process for 10 years b. Outlier payments for hospitals with extraordinarily high capital costs

This statement is prepared on behalf of the 229 public and voluntary, not-for-profit hospital members of the Hospital Association of New York State (HANYS).

Statement of the Issue

When Congress enacted the Medicare Prospective Payment System (PPS) in 1983, it excluded payments for certain hospital expenditures from incorporation into the new payment system. Expenditures for direct graduate medical education costs would be paid on the basis of a reasonable cost pass-through since not all hospitals were involved in medical education programs and to incorporate such costs into PPS would be a distortion of the payment mechanism. At the same time, payment for capital costs were also excluded from PPS - to continue on a reasonable cost pass-through basis - at least until October 1, 1986. Section 1886(a)(4) of the Social Security Act - as added by P.L.98-21 - specifically excludes from the definition of operating costs for hospital inpatient services capital costs "incurred in cost reporting periods beginning prior to October 1, 1986."

At that time, it was the intent of Congress, as expressed in the Conference Report (House Conference Report No.98-47) that capital would be incorporated into PPS by legislation prior to October 1, 1986. The legislation, however, did not preclude the Secretary of Health and Human Services (HHS) from incorporating capital into PPS by regulation after October 1, 1986. In addition, the legislation also required the Secretary to submit a report to Congress, by October 1984, containing "a thorough review of the methods by which capital, including return on equity, can be incorporated into the prospective payment system." That report has only recently been submitted, fully 18 months after the due date.

Current Status

Prior to the submission of the Congressionally mandated report, the Department of Health and Human Services, as part of the Administration's Fiscal Year (FY) 1987 budget, outlined a proposal for the incorporation of capital into the Medicare Prospective Payment System (PPS) by regulation. In all likelihood, this proposal will be included in the overall PPS regulations to be published in the Federal Register by June 2, 1986. The HHS proposal is clearly budget driven - it seeks a $456 million reduction in Medicare capital outlays in FY 1987 and $11.1 billion over a five year period. The HHS proposal would base capital payments on a blend of 1983 national Medicare capital expenditures and the lesser of 1986 hospital-specific capital or current year capital expenditures. HHS plans to eliminate from the 1983 national base year expenditures several important elements, including return on equity, interest on funded depreciation accounts, and donated assets. Over a four-year transition period the hospital-specific portion of capital incorporated into PPS would be eliminated and by FY 1991 the capital payment level would solely reflect average national payments per discharge.

The HHS proposal is inherently flawed for several reasons:

A. Authority

The Administration wants to do this by regulation, without affording Congress the opportunity to consider the Secretary's report on alternative approaches.

It must be done by statute and the effective date must be postponed for at least one year.

B. Budget cut

The Administration projects a $456 million saving the first year and $11.1 billion in five years.

Medicare capital payment policy must be based on sound policy and not be a tool for cutting the budget.

C. Base Year

The Administration proposes a 1983 base year.

The 1983 base is outdated and no longer reflects hospital cost structures.

D. Update Factor

The Administration believes that the Secretary should define the update factor.

This will become a tool for deficit cutting.

E. Transition

The Administration proposes a four-year transition.

This transition is too short and unrealistic.

F. Indirect Medical Education

The Administration does not propose any adjustment for indirect medical education; i.e., they don't recognize any difference between teaching hospitals and community hospitals.

G. Medicaid Reimbursement

The Administration proposes to indirectly limit Medicaid reimbursement for capital to what Medicare pays.

States should be given flexibility.

The Hospital Association of New York State is strongly opposed to the HHS proposal as being violative of Congressional intent and the basic principles of fairness and equity. In addition, we oppose any proposal which is solely budget driven and not based upon the development of a sound and rational policy designed to meet the capital needs of hospitals and the patients they serve.

There are several additional proposals for incorporating capital into PPS. Senator David Durenberger's proposal (S.2121), which differs primarily from the HHS proposal in the length of the transition period (7 years) to a national payment amount. The Congressionally established Prospective Payment Assessment Commission's (PROPAC) proposal recommends distinctions between building and fixed equipment versus movable equipment, retains return on equity and interest on funded depreciation accounts within the federal portion of payment rates, includes the possibility of a regional adjustment factor and would also provide for a longer transition period than the HHS proposal. While our Association is not prepared to endorse the PROPAC recommendations as currently put forward, we believe their proposal contains several provisions worthy of serious consideration by Congress in the development of a capital payment policy for Medicare.

Immediate Decisions that Must be Made by Congress

It is the strong belief of our Association that only Congress has the ability to consider the many issues and implications involved and to develop a fair and equitable policy for the incorporation of capital into Medicare PPS. This belief is especially strengthened by the recent manipulation of PPS by HHS through the regulatory process in violation of Congressional intent to implement a fair, equitable and predictable payment mechanism for hospital services to Medicare beneficiaries, as well as HHS' continual failure to submit Congressionally mandated reports on PPS, and to implement Congressionally mandated refinements and adjustments in the payment mochanism.

Congress must maintain its appropriate role in the development of Medicare policy, we therefore urge the immediate adoption of an explicit statutory prohibition on HHS from incorporating capital into PPS through regulations planned to be published by June 2, 1986. This is an essential first step in the process of Congressional development of a Medicare capital payment plan for hospitals.

Should Capital be Incorporated Into PPS, and If So, When?

The issue of whether Medicare payments for capital should be incorporated into PPS is still a valid one for serious national debate. While Congressional intent, as expressed in the 1983 PPS legislation, was that such was to be accomplished by October 1, 1986, that intent was also premised on the assumption that a Congressionally mandated report on the issue from HHS would be submitted by October 1984. That report - which could have served as the focus for the development of Congressional capital payment policy - has, as previously indicated, only recently been submitted. In its absence, we are confronted with a budget driven proposal from HHS and several competing proposals.

On the broad questions of whether capital payments should be incorporated into PPS, there are several strong arguments on both sides of the issue. It can be argued that the incorporation of capital into PPS is consistent with the goals of administrative simplicity, flexibility for hospital management, predictability of payment, and incentives for efficiency - all goals of PPS generally. We question, however, whether these goals have been achieved for PPS based on HHS' manipulation of Congressional policy intent through regulation, as well as its failure to comply with several clear Congressional mandates.

On the other side, it can be argued that the treatment of capital separate from PPS is the most equitable method of dealing with such expenditures. The separate treatment of capital is able to address hospital specific needs especially as it relates to variations in capital commitments, regional differences in capital construction costs, the age and useful life span of physical plants, and the need to maintain a viable hospital infrastructure. In addition, such a system also avoids the oversimplification of the broad policy issues inherent through development of a national average payment approach.

For New York State's public and voluntary, not-for-profit hospitals, the incorporation of Medicare capital payments into PPS would be devastating, and is based on several misguided principles.

New York State Hospitals Continue to Generate Operating Losses

Hospitals in New York State do not generate operating surpluses that can be used to cover capital expenditures. As Table 1 indicates, public and voluntary hospitals in our State continue to incur substantive operating deficits on a year to year basis.

In 1984, 65.5 percent of our 229 public and voluntary hospital members incurred operating losses. Assuming that our all-payor reimbursement system had not been in place during 1983 and 1984, 83.0 percent of our hospitals would have had operating losses in 1984 after exclusion of our special pool funding mechanisms. Even so, average hospital operating losses increased 17.5 percent, from $1.631 million in 1983 to $1.916 million in 1984.

The future does not hold the promise of attaining long sought financial stability. For 1985, we project aggregate operating losses of $323 million and between $322-$390 million in 1986. Assuming continuation of our current payment system through 1987, we project aggregate operating losses of between $553 million and $654 million in that year. Clearly, changes in Medicare's treatment of capital, as well as other potential changes in PPS that might be implemented this year, will only serve to exacerbate the already weak financial condition of New York State's public and voluntary, not-for-profit hospital sector.

New York State Hospitals Are Unable to Absorb Revenue Losses Through Cross-Subsidization

Unlike hospitals in other parts of the country, hospitals in New York State cannot cost shift, or cross subsidize, losses in Medicare revenues from higher charges to other payors. Article 28 of New York State's Public Health Law gives the Commissioner of Health extensive regulatory authority in the determination of rates of payment for services to Medicaid and Blue Cross beneficiaries, as well as limitations on allowable charges to other third party payors and private paying patients. As such, hospitals in our State have limited ability to offset operating losses through patient care revenues. For the most part, operating losses are sustained through under-funding of funded depreciation accounts, using what little equity is available, diversion of philanthropy for working capital purposes, short-term debt financing, and delays in routine physical plant maintenance.

Wide Variations in the Capital Needs of New York State's Hospitals

The incorporation of capital payments into PPS is predicated on the belief that all hospitals have the same capital needs. This approach will either reward or penalize a hospital depending on the age of its physical plant. Facilities that were recently constructed or renovated, or facilities that are currently under construction will be penalized by this system. For most of these facilities, even a ten year transition won't be long enough. As illustrated by Chart 1, the average age of physical plant for New York State's hospitals is older than the nation as a whole.

In New York State, 63.3 percent of hospitals have capital expenditures that exceed 7.0 percent of total expenditures. As illustrated by Table 2, there are wide variations in the ratio of capital expenditures to operating costs in New York State. Those with high ratios would obviously be imperiled by a normative dollar amount to PPS pricing levels. Not so obvious are the serious consequences for those hospitals with low capital to operating cost ratios. Those institutions, by definition, have capital assets that are nearly fully depreciated and obsolete. They are not competitive and will suffer declines in volume, and therefore further reductions in capital payments.

Since 1983 -- the mythical dividing line between old and new capital -- 19 New York State hospital projects, with a value of over $10 million, received certificate of need (CON) approvals for projects valued at approximately $1.45 billion in the aggregate. Clearly, the commitments made by these facilities must be recognized under any new methodology.

The ability of older facilities, especially those in very poor financial condition, to rebuild or maintain physical plant may never be accomplished. Rebuilding under a system which incorporates Medicare capital payments into PPS depends on a facility's ability to either fund depreciation or accumulate equity. Many hospitals in New York State must subsidize operations by robbing funded depreciation accounts or equity funds.

New York State Access to Capital Bond Markets

The incorporation of capital into PPS is also based on the assumption that all hospitals can obtain the same interest rates in the credit markets. However, due to our poor financial condition -- as previously illustrated -- this is not the case for hospitals in New York State. The potential loss of access to tax-exempt bond financing will further increase our interest costs to the extent we are able to gain access to the more costly taxable bond market. In addition, hospitals in our state have been extremely dependent upon federal loan guarantees under section 242 of the FHA Mortgage Insurance Program as a means of gaining access to the bond markets at favorable interest rates. At the end of 1983, New York State hospitals represented 46 outstanding FHA loans (26% of nationwide total) aggregating $1.7 billion (47% of nationwide total). By contrast, between 1975 and 1984 only 17 hospitals have borrowed an aggregate of $475 million on the security of their own credit, commercial bond insurance or, in two instances, endowments. Yet this program, which is an integral part of capital payment policy, has been operating on a series of temporary continuing resolutions since September 30, 1985. As Charts 2 through 5 illustrate, the financial ratios of New York State hospitals compare less favorably in several respects to ratios for hospitals in the nation as a whole. Finally, the credit worthiness of our hospitals is further diminished by the large amount of uncompensated care provided in our facilities. In 1986, such care is expected to approach $1 billion.

New York State Hospitals Continue to Operate in a Regulatory Environment

Proposals to incorporate capital into PPS are also based on the assumption that hospitals are free to decide when and how to make capital investments. However, hospitals in New York State must operate under the oldest and most restrictive certificate-of-need (CON) process in the country. We build when we get CON approval, not when interest rates are the lowest. In addition, New York State building requirements are overly prescriptive, adding to the cost of construction.

New York State's Teaching Hospitals Treat a Severely Ill Patient Population

The incorporation of capital into PPS is also based on the notion that all hospitals treat the same kinds of patients. This approach discriminates against teaching hospitals and large academic medical centers. The current Medicare pricing mechanism does not recognize severity of illness within individual diagnostic related groups (DRGs). Within any DRG, teaching hospitals and large academic medical centers are more likely to admit (or receive as a transfer from a community hospital) patients who are more severely ill. As a result, teaching hospitals must acquire more sophisticated types of equipment and build more elaborate physical plants.

This is a problem for New York State because of the large number of teaching hospitals and patient transfers from other states. In fact, a disproportionate share of hospital operating deficits, as illustrated by table 3, are generated in the teaching hospital sector.

Needs of New York State's Rural Hospitals Are No Less Than Those Elsewhere

Finally, the incorporation of capital into PPS ignores the needs of small and rural hospitals. Many rural hospitals in New York State and across the nation -- not just sole community providers -- may never generate sufficient capacity. Hence, by definition, they will lose money under this system. Are we ready to close small community hospitals across the nation?

It is not our intent to engage debate on this issue in this statement. But to only raise the broad policy questions which need to receive more thorough discussion and debate.

As such, our Association strongly urges Congress to delay for one year -- until October 1, 1987 -- the effective date of Medicare's incorporation of capital payments into PPS. We believe that such a delay would provide further time to adequately address the policy issues involved, as well as to focus discussion in an atmosphere conducive to the development of fair and equitable policy, and not one driven solely by budgetary considerations. While it may be expedient to quickly incorporate capital into PPS payments, the consequences of a simplistic approach would be disastrous for New York State's hospital system.

Basic Principles for the Incorporation of Capital into Medicare PPS

Although any system that creates a single price for hospital services has many disadvantages, we realize that Congress cannot ignore this issue. If Congress does not enact legislation, many believe that the Secretary has the authority to incorporate capital cost reimbursement into the prospective pricing system through regulation. We believe that this issue must be addressed through statute and not through regulation. Therefore, we again urge Congress to repeal the Secretary's authority to adopt a new capital cost reimbursement system through regulation.

While the present Medicare "pass-through" of capital costs has several inherent flaws, the incorporation of capital costs into a single price, based on extant proposals is more flawed. The proposed solution is surrounded by controversy and we have little idea about the long term effects of this policy. For this reason, we again believe that Congress should delay acting on this issue for one more year.

When Congress acts it should be mindful of several basic principles.

1) While there may be a great temptation to cut the federal budget deficit by reducing Medicare capital payments, any new methodology must not be used as a vehicle to achieve budget savings.

2) Congress must recognize that existing federal health planning law and certificate of need (CON) laws in many states links the determination of need with reimbursement. Therefore, in those states which require a regulatory assessment of community need and link it with the federally financed health planning program, capital costs should be passed through.

3) There must be a reasonable transition. The transition to a federal rate for building and fixed equipment must be at least 12 years, and the transition for movable equipment must be at least 5 years.

4) The federal portion of the capital rate must be based on data for the most recent 12 month period prior to the effective date of the new methodology.

5) The hospital specific portion of the capital rate must be based upon each year's actual expenditures.

6) The capital rate must recognize the additional cost of graduate medical education, as well as the additional costs to hospitals that serve the medically indigent.

7) A new capital cost methodology must be coupled with a repeal of section 1122, and a federal pre-emption of state assessment of Medicare revenues for the purposes of creating a state operated capital funding pool.

8) A new methodology must provide for exceptions and exemptions especially for inner-city and rural hospitals. In addition, it must make special provision for facilities that recently undertook capital projects.

9) A new methodology must recognize the distinction between old capital and new capital. Old capital must be defined as capital already expended or for projects under construction prior to the effective date of the new methodology.

10) A new methodology must recognize regional differences in construction costs.

11) Finally, any federal policy regarding Medicare treatment of capital expenditures must be a part of - and cannot be divorced from - a broader federal policy regarding hospital access to capital. As such, that broader federal capital policy must also include the preservation of voluntary, not-for-profit hospital access to tax-exempt bond financing as well as the continuation of federal loan guarantees under section 242 of the FHA Mortgage Insurance Program.

Summary and Conclusion

To re-emphasize our basic points, the development of Medicare capital policy is a Congressional issue and one that must not be left to regulation alone. We believe that a one year delay in implementation of this new policy would provide the time necessary to develop proposals based on fairness and equity in an atmosphere conducive to the serious consideration of public policy issues. We believe any proposal must be based on the set of principles we have outlined in this statement.

Our Association stands ready to expand on any of the issues we have dealt with here and to provide the Subcommittee any assistance they might require when they undertake policy development in this important area.

TABLE 1

NEW YORK STATE HOSPITALS
OPERATING LOSSES BY GEOGRAPHIC LOCATION
(in millions)

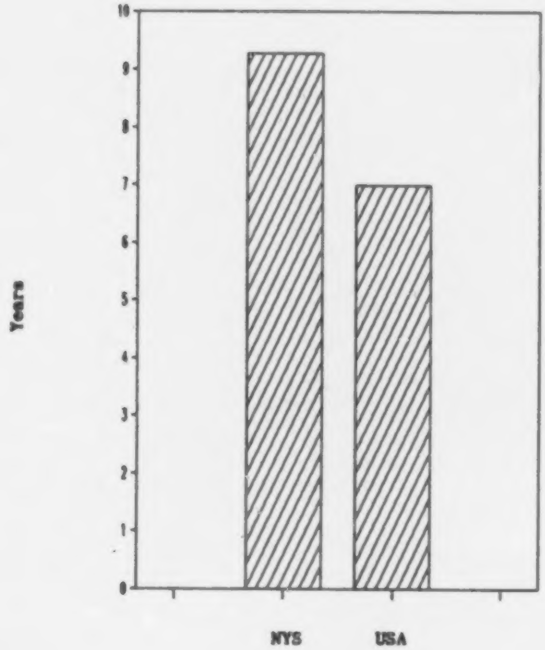
Region	1982	1983	1984
New York City	$(165.2)	$(116.7)	$(134.4)
Nassau-Suffolk	(36.5)	(28.7)	(40.1)
Northern Metropolitan	(42.8)	(32.5)	(32.1)
Albany	(11.0)	(7.5)	1.4
Utica	(8.0)	(7.7)	(5.0)
Syracuse	(18.3)	(12.7)	(18.7)
Rochester	(3.8)	6.3	3.3
Buffalo	(24.0)	(41.5)	(24.1)
Statewide	$(309.7)	$(240.9)	$(249.8)

CHART 1

Average Age of Plant

New York State vs. United States

1984



Definition:

Accumulated Depreciation divided by Depreciation Expense

TABLE 2

NEW YORK STATE HOSPITALS
RATIO OF CAPITAL EXPENDITURES TO OPERATING COSTS

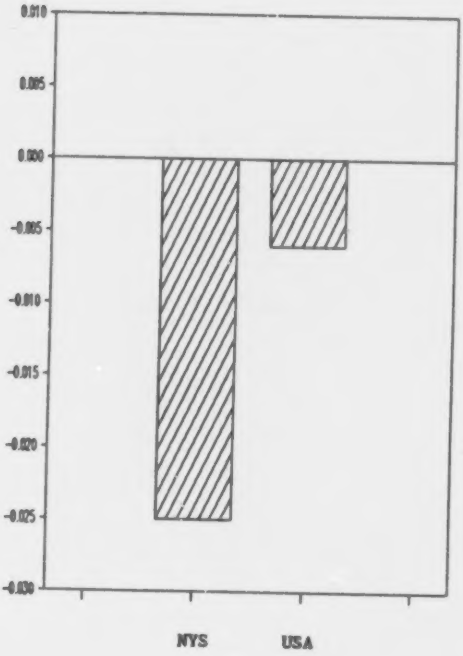
Capital Percent Range	Number of Hosp.	Cumulative Number	Percent of Hosp.	Cumulative Percent	Average Capital Percent
0 - 1	0	0	0.00%	0.00%	0.00%
1 - 2	6	6	2.34%	2.34%	1.67%
2 - 3	6	12	2.34%	4.69%	2.55%
3 - 4	25	37	9.77%	14.45%	3.63%
4 - 5	18	55	7.03%	21.48%	4.60%
5 - 6	19	74	7.42%	28.91%	5.45%
6 - 7	20	94	7.81%	36.72%	6.60%
7 - 8	23	117	8.98%	45.70%	7.35%
8 - 9	22	139	8.59%	54.30%	8.44%
9 - 10	18	157	7.03%	61.33%	9.49%
10 - 11	18	175	7.03%	68.36%	10.55%
11 - 12	12	187	4.69%	73.05%	11.42%
12 - 13	8	195	3.13%	76.17%	12.39%
13 - 14	4	199	1.56%	77.73%	13.57%
14 - 15	8	207	3.13%	80.86%	14.31%
15 - 20	23	230	8.98%	89.84%	16.66%
20 - 25	11	241	4.30%	94.14%	21.72%
25 - 30	6	247	2.34%	96.48%	28.78%
30 - 35	5	252	1.95%	98.44%	32.64%
35 - 40	2	254	0.78%	99.22%	37.70%
40 - 45	2	256	0.78%	100.00%	42.84%
Total	256	256	100.00%	100.00%	11.92%

CHART 2

Operating Margin

New York State vs. United States

1984



Definition:

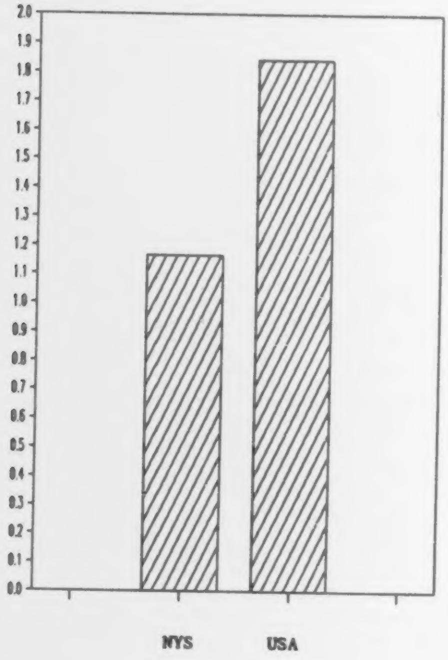
Total Operating Revenue less Total Operating Expenses divided by Total Operating Revenue

CHART 3

Current Ratio

New York State vs. United States

1984



Definition:

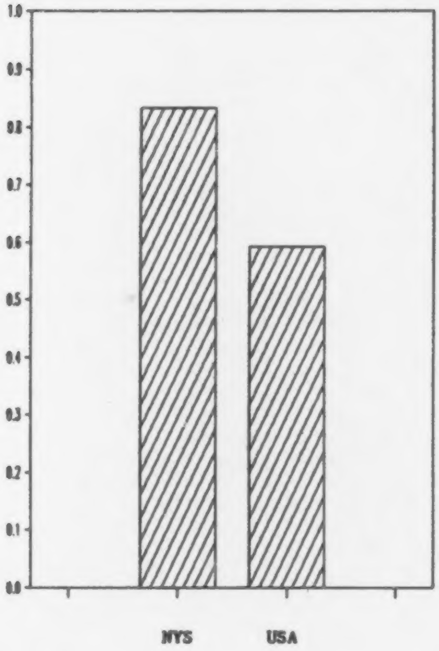
Current Assets divided by Current Liabilities

CHART 4

Fixed Asset Financing Ratio

New York State vs. United States

1984



Definition:

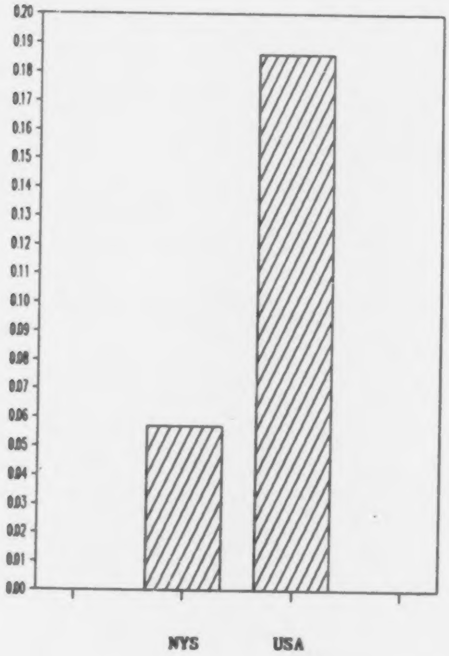
Long Term Liabilities divided by Net Fixed Assets

CHART 5

Cash Flow to Total Debt Ratio

New York State vs. United States

1984



Definition:

Excess of Revenues over Expenses plus Depreciation Divided by the sum of Current Liabilities and Long Term Debt

TABLE 3

NEW YORK STATE
OPERATING LOSSES FOR TEACHING HOSPITALS

	1982	1983	1984
New York City	$(135.4)	$ (90.5)	$(117.8)
All Other NYS	(77.6)	(82.2)	(83.5)
TOTAL	$(213.0)	$(172.6)	$(201.3)

STATEMENT OF FRANCIS J. BYRNES,
CHAIRMAN, HEALTHCARE FINANCING STUDY GROUP,
BEFORE THE SENATE FINANCE COMMITTEE,
SUBCOMMITTEE ON HEALTH,
ON MEDICARE REIMBURSEMENT FOR CAPITAL COSTS
MARCH 14, 1986

Introduction

These comments are submitted by Jack Byrnes, Manager of the healthcare group at PaineWebber and current Chairman of the Healthcare Financing Study Group. The HFSG is a trade association of approximately 50 national investment bankers and underwriters working in the healthcare field. Our members typically have 10-20 years' experience in financing healthcare facilities, and we have all been closely involved in developing financing tools to accomodate the enormous structural and payment changes occurring in this area. My comments draw on my own experience and that of my colleagues in working with hospitals to cope with these changes.

Pressures on Hospital Financing

The debate over how to treat capital in the Medicare reimbursement system comes at a time of significant financial pressures for hospitals. While the effects of the prospective payment system on the operating side have produced some needed efficiencies, they have also squeezed margins for some institutions -- particularly the large urban and small rural hospitals -- into the 1% range. For such institutions, and for any which had to undertake capital projects during the high interest rate period of the late 1970s, a move away from straight reimbursement will impose additional financial pressures.

The discussion of Medicare capital reimbursement also comes at a time when Congress is contemplating tax revisions which will surely reduce the nonprofit hospital sector's ability to obtain capital at reasonable rates through the use of tax-exempt bonds. The House has passed a tax reform bill, H.R. 3838, which would reduce nonprofit hospital bond volume significantly through what is effectively a $25 per capita volume cap. I have included a more detailed discussion of the impact of this cap in Appendix A to this statement. H.R. 3838 would also strip hospitals' ability to reduce capital costs by lowering debt service or undertaking restructuring by means of advance refundings. The tax-exempt bond proposals under discussion in the Senate (the Packwood Finance staff option and Senator Durenberger's bill, S. 2166), would impose some restrictions on advance refundings and, in the case of S. 2166, subject hospitals to a unified volume cap of $225 which must accomodate all other nongovernmental bonds except targeted multi-family housing.

My point in mentioning these legislative initiatives is to stress that Medicare reimbursement for capital cannot be considered in isolation. If Congress does eventually subject hospital bonds to volume caps and/or restrict advance refunding in the course of tax reform, hospital capital costs will inevitably jump significantly. To the extent that Medicare capital reimbursement covers some of those costs, the increase will be transferred back to the Federal Treasury. To the extent that Medicare does not cover those costs and hospitals come up short, they will have no choice but to lower non-capital costs by reducing the quality of care provided. Particularly if the tax laws cut off the ability to lower debt service through advance refunding, capital costs cannot be lowered; debt service on capital improvements is a fixed expense for the life of a project. In short, we urge you to consider the adverse effects of proposed tax law changes on hospitals and the Medicare system as you develop legislation on capital reimbursement.

Needs for Healthcare Capital

One other preliminary subject should be addressed before we state our recommendations on capital reimbursement: the needs and uses hospitals have for capital in the current environment. A persistent misconception seems to haunt health policymakers -- that hospitals are continuing to expend capital for needless expansions in inpatient bed capacity. This simply is not the case. The vast majority of uses and needs for new capital are for modernizations and renovation of aging existing facilities to meet life safety codes and technological change, and/or shifts to more efficient forms of healthcare such as outpatient facilities, skilled nursing facilities, health maintenance organizations, ambulatory surgery, and integrated health delivery systems.

These changes were already being reflected in data developed from our membership in 1984. A survey our Group conducted on the uses and impacts of hospital financing shows that the majority of issues of tax-exempt debt for hospitals in 1984 have not been for construction of increased bed capacity. In 1984, 69.8% of financings did not result in bed increases. In fact, nearly 10% of financings in 1984 resulted in decreased bed capacity. Of those projects that did involve bed expansion, 69% of volume in 1984 occurred in the growing Sunbelt region, where new facilities are needed due to population growth, particularly among the aging. In short, there is real need for hospital capital in the coming decades. Now let us turn to the proposals for addressing those needs in the Medicare reimbursement system.

Phased Capital Passthrough

Pending proposals (the Administration's plan and the Durenberger bill, S. 2121) employ a phased methodology, wherein capital cost reimbursement shifts from a hospital-specific to a national calculation over time. A phased approach to capital payment presents two problems. First, a phased system penalizes any institution with high current capital costs as the national portion becomes dominant. Such a system is unfair to those institutions which had no choice but to incur capital costs during periods of high interest rates. The impact of the Administration's proposal on such institutions would, in some cases, cause capital shortfalls as large as or larger than operating profits. Even leaving the issue of fairness aside, arbitrarily causing economic hardship for any institution with high historic costs will, as I have suggested, inevitably have adverse effects on the quality of healthcare.

Second, a flat payment for historic capital costs, regardless of the timing, indiscriminately creates windfalls as well as hardships. There is no reason to reward institutions with below-average capital costs any more than there is to penalize those with higher than average costs. This is especially true where the result would be to enhance arbitrarily the financial positions, and prolong the lives, of some poorly managed institutions which perhaps should go out of business.

The "Hold Harmless" (Old/New Capital) Alternative

A more efficient and equitable alternative to a phased approach is to reimburse capital costs incurred prior to the introduction of the proposed legislation on a historic basis, while reimbursing all capital costs incurred after that date on a flat fee, national basis, with no transition period. The advantages of this system are as follows.

First, healthcare institutions would be "held harmless" for actions based on rules applicable at the time those actions were taken. Similarly, decisions on future expenditures could be made on rational basis, since the limits of reimbursement would be known, and management could reasonably be held accountable for the consequences. That is not true of decisions on capital undertakings made up to now. Although a possible change in Medicare reimbursement was contemplated in theory before 1986, new rules were not established -- and still have not been established -- leaving hospitals no choice but to follow current law.

Second, the lives of inefficient or poorly run institutions which happen to have low capital costs (in part because they have deferred needed renovations or modernizations) would not be arbitrarily prolonged.

Third, hospitals incurring new capital costs would not receive excess reimbursement on their hospital-specific portion during what would have been the early years of a phased program; likewise, hospitals with below-average costs would not receive windfalls in the later years of a transition.

The nature of a DRG-based capital reimbursement system makes it difficult to generalize about the economic consequences of any approach. However, if one assumes any fixed-fee system would be based on a true average of capital costs, our proposal should be no more expensive than a phased alternative. It simply avoids the arbitrary reallocation of capital based on historic costs. In fact, our proposal might well prove to be less expensive, since reimbursement on the hospital-specific portion would diminish as the existing capital base depreciates.

Imperative for Congressional Action

Although we can appreciate the budgeting pressures which affect any discussion of capital reimbursement, a phased approach will allocate capital without regard to fairness, efficiency, or social good. The Administration's proposal is especially unfair and ill-advised because it 1) employs a national rate base year (1983) which greatly understates current Medicare capital commitments; 2) uses 1986 for the hospital-specific rate, penalizing hospitals which have undertaken commitments in the last 3 years; 3) includes an unfair retroactive penalty by removing interest on funded depreciation and return on equity from the capital base; and 4) sets a 4-year transition which will not permit most institutions to adjust to the new limitations.

We urge that the Administration not be allowed to usurp Congressional authority by implementing this plan. Full Congressional attention to this critical and complex matter is needed, particularly so that the Medicare capital reimbursement issue not be treated in isolation from the other pending Congressional initiatives affecting hospital capital. We strongly recommend that Congress move immediately to prevent the Administration from taking regulatory action without legislative guidance.

Conclusion

Inequitable and rushed changes in capital policy, such as those proposed by the Administration, harm hospitals and their patients in the short run. In the long run such action will impede hospitals' ability to maintain high quality while moving to a more efficient healthcare delivery system. We urge Congress to take the leading policymaking role in this area, and to consider in doing so an old capital/new capital method which avoids the inequities and inefficiencies inherent in a phased approach.

health industry
manufacturers
association
hima

[illegible]

STATEMENT ON MEDICARE CAPITAL PAYMENTS

SENATE FINANCE COMMITTEE

MARCH 14, 1986 HEARING RECORD

The Health Industry Manufacturers Association (HIMA) is the trade association representing approximately 300 manufacturers of medical devices and diagnostic products, including major manufacturers of capital equipment. We appreciate this opportunity to present our views on capital financing under the Medicare program.

When Congress passed the prospective payment law in 1983, it demonstrated clear intent that the capital issue should be resolved by Congress. We applaud this committee's attention to capital and oppose the Administration's proposal to deal with capital by regulatory action.

Capital has been one of the most controversial issues in prospective payment. The position of each hospital is unique, and it has been impossible to construct a capital payment proposal that has treated all hospitals equally well.

But midnight draws near. If Congress does not act by October 1, capital policy turns not into a pumpkin but into a turkey: the Administration gets its plan, along with onerous and unnecessary Section 1122 controls. We urge the Congress to act and, if it cannot act by midnight, to defer the October 1 deadline and delete the Section 1122 controls.

an association representing the medical device and diagnostic product industry

Largely ignored so far in the long capital debate has been a key question: how can capital payment assure that beneficiaries receive value from the Medicare program? The health of Medicare patients is, after all, the thing that should truly drive this and other debates about the Medicare program.

What then, should Medicare beneficiaries expect from the Medicare payment system with respect to capital?

First, that they will receive care in safe, reasonably comfortable facilities with up-to-date equipment.

Second, that they will in the future receive care that keeps pace with advances in basic and clinical research through continuously upgraded plants and equipment. Capital technologies, even today, keep patients healthier than ever before through earlier and more accurate diagnoses, less invasive procedures, fewer complications and infections, and faster rehabilitation. Patients have a right to tomorrow's advances, too.

Third, that they will receive care both now and in the future at a cost that represents sound value; that is, at a cost that is not inflated by unnecessary capacity or utilization, but that is related closely to the needs of patients.

Fourth, they have the right to expect that budget policy will not masquerade as health policy. The Administration should admit that its true priority is the budget, if it so believes. If that is the case, we fear Medicare's days as a patient's program are numbered.

What does this mean for capital policy?

First, capital policy must recognize that investment in facilities and equipment is a continous process. It is inevitable that facilities will deteriorate. It is, we know, inevitable that the number of Medicare beneficiaries will grow. It is, we believe, inevitable -- because of changing patient treatment patterns -- that Medicare beneficiaries in hospitals will be more seriously ill than in the past and require a higher intensity of care. It is, we hope, inevitable that at least some minimal level of procedure and product innovation will occur. But the extent and potential of that innovation are very much dependent on the kind of capital policy we have.

Medicare capital payments must be adequate to maintain the capacity to serve the beneficiaries, must be predictable for the institutions that provide this capacity, must enhance institutional ability to innovate and, during a transition period, should provide a fair opportunity for institutions to adjust to whatever new method of payment may be adopted.

Taking these points in reverse order, we have the following observations:

1. Adjustment Period. A fair adjustment period is critically important, especially the short term. A ten-year period seems reasonable. In contrast, the four-year period provided by the Administration's proposal is simply a punitive measure against hospitals which in good faith incurred obligations to continue to provide value to Medicare beneficiaries.

Hospitals should not gain or lose because of decisions made under a prior set of rules. Because of the difficulty of dealing with all hospital capital situations fairly with a single transition period, it seems desirable to establish some sort of exceptions process that is sensitive to individual hospital costs -- the best barometer of capital's cyclical nature. While this implies some cost reporting, we believe this is a reasonable trade-off for a more accurate and equitable policy.

2. Encouraging Innovation. This is the most important objective to be achieved by capital payment. Hospitals -- and the entire health care system -- are in a time of fundamental change. Nothing is more important than the ability of health care institutions to do things in different ways, with different people, and with new technology. Hospitals cannot innovate, cannot change constructively, if capital payments assume that investing in innovation is either unnecessary or free. Such an assumption also exerts an untoward effect on the innovator's appetite for new product development.

Let us pause to debunk a myth -- the myth that the current capital payment system has resulted in excessive hospital spending for equipment purchases. In fact, tight DRG prices for operating costs also constrain capital. Machines, standing there by themselves, don't cure patients; but machines, together with the people operating them, do. Use of capital equipment is inextricably linked to operating budgets, and hospitals know that their operating budgets have been strictly constrained by prospective payment.

3. Payment Predictability. Sound policy does not require absolute certainty of payment level, but it does require a degree of consistency from year to year that has been obviously lacking from the inception of Medicare prospective payment.

Let's go back to why prospective payment was legislated. It was intended to increase value for patients by forcing hospitals to live within a prearranged per-case budget. For this to work, hospitals must know the budget and have the freedom to respond to it.

Capital policy should remain faithful to these principles. Medicare should pay hospitals a single amount per DRG that is adequate and realistic. While reflecting both operating and capital costs, the payment amount should be the hospital's to allocate in a way that will meet the budget and serve the patient.

To do this, hospitals must know what their budgets are. The Administration's creative use of technical adjustments to cut DRG payments instills little comfort. For capital, we urge a calculation separate from the standarized amount, with which the Administration annually toys enroute to DRG price cuts. Instead, Congress should legislate a reasonable schedule of capital payment levels that could only be changed by Congress itself. The payments in this schedule would be combined with payments for operating costs to form a single payment amount for each DRG.

4. Payment Adequacy. Investing in changes, in the improved capacity to serve Medicare beneficiaries, doesn't come free. Hospitals are not car washes. To take care of sick people requires expensive facilities, an ever-changing inventory of appropriate technology, and highly skilled people. None of this can be maintained on the cheap.

These four points, while important, do not fully remedy prospective payment's disincentives toward certain new capital technologies. Prospective payment encourages adoption of technologies that cut costs on a per-case basis. It discourages adoption of technologies that cut costs longer term by reducing admissions or that, while costing more, do more for the patient. Congress should establish a mechanism for removing the disincentives prospective payment holds for some new capital technologies.

With all this in mind, what can be said of existing proposals?

S. 2121, the Durenberger bill, takes capital payment as the serious policy issue it is. It repeals Section 1122 controls and provides for a transition period that correctly bases hospital-specific payments on actual costs. On the other hand, it contains no exceptions process, provides for a transition period of seven years, and computes capital payments with reference to the standarized amount, thus allowing the Administration opportunity for mischief. S. 2121 could also be improved by using a rolling base period, so that capital payments are not forever tied to the early to mid-1980's.

The Administration proposal is misguided in a number of respects: it provides too short a transition period and employes an update index that seems designed more to produce a low number than adequate payments. And of course, it has the major defect of contemplating no Congressional involvement.

But the fundamental defect of the Administration's proposal is that it tries to disguise budget policy as health policy. It treats Medicare capital payment as a target for budget savings rather than as a necessary investment in maintaining services to Medicare beneficiaries. That's the issue around which the debate should revolve.

Finally, we voice our opposition to the transition period recommendation of the Prospective Payment Assessment Commission (ProPAC). While suggesting on the one hand that bricks and mortar and fixed assets be given a seven-to-ten year transition period, ProPAC recommends no transition at all for movable equipment. This is a distinction without a difference. The split ProPAC recommends would be artificial, difficult to administer, and inconsistent with sound hospital planning.

We appreciate this opportunity to comment and pledge our cooperation to the Committee and its staff.

STATEMENT SUBMITTED
BY THE
NATIONAL ASSOCIATION OF REHABILITATION FACILITIES

TO THE HEARING RECORD OF THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON FINANCE
U.S. SENATE

FOR ITS HEARING ON
S. 2121, THE FAIR DEAL CAPITAL PAYMENT ACT

STATEMENT SUBMITTED BY THE NATIONAL ASSOCIATION OF REHABILITATION FACILITIES TO THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON FINANCE

This statement is submitted by the National Association of Rehabilitation Facilities to the Subcommittee on Health in connection with the Subcommittee's consideration of proposals to include capital costs in the Medicare prospective payment system. Our statement is addressed to the proposal advanced by the Reagan Administration, as outlined in the statement of Robert Helms, Acting Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services and S. 2121, the Fair Deal Capital Payment Act and particularly on how these proposals may or may not bear on rehabilitation hospitals and rehabilitation units in general hospitals excluded from the medicare prospective payment system.

NARF is the principal national membership organization of medical and vocational rehabilitation facilities. Most of the freestanding rehabilitation hospitals in the country and a good number of the rehabilitation units are our members. We wish to call the attention of the Subcommittee to the unique characteristics of these facilities and the special consideration that must be given to these characteristics in fashioning legislation to deal with Medicare payment for capital costs.

Mr. Helms stated in his testimony that the Administration believes it has the authority under Section 1886(a)(4) to change the payment methodology for capital payments under Medicare by regulation. While his entire testimony speaks only of hospitals under the PPS, we understand from conversations with the Department that it has a policy allowing it to change capital payments for Medicare excluded hospitals and units by regulation as well. Changes made by regulation would not result in any significant budgetary savings, but would prove highly disruptive to the excluded facilities. We recommend that Congress enact legislation prohibiting the Secretary from promulgating any regulations pursuant to the Social Security Act which would effect or change payment for capital expenses under Medicare.

First, it may be helpful to describe the nature of these facilities and the services they provide. Rehabilitation is addressed to restoration of function for people whose capacities are impaired by injury, disease or congenital defects. Rehabilitation is a fairly recent addition to the health care system having developed largely since World War II. Through a combination of coordinated therapies, rehabilitation seeks to assist patients to gain or regain optimum levels of function in movement, cognitive capacity and other areas. Unlike most acute services that are focused on treating a patient by doing things _to_ him or her, rehabilitation is concerned with helping to improve the patient's ability to function by working _with_ the patient. The individual services that are generally included in a coordinated program of rehabilitation are physical, occupational, and speech therapy, prosthetics and orthotics, audiology and additional supporting therapies.

Rehabilitation is becoming of increasing significance to the population covered by the Medicare program, because of the high incidence of certain disabling conditions among older people, particularly stroke. Stroke patients constitute far and away the largest group of Medicare patients seen in inpatient rehabilitation facilities.

The nature of the services provided by rehabilitation hospitals and units makes them very different in their operating characteristics. NARF recently completed a study of the industry and its characteristics. We found, as anticipated, that lengths of stay are substantially longer than in acute care hospitals, by a factor of four or greater depending on the patient's condition. The average length of stay is over 34 days for all patients. In some facilities specializing in such severe problems such as spinal cord injury, the length of stay is considerably longer, as high as 90 days or more. The current length of stay for PPS hospitals is about 7.6 days.

When the Medicare PPS system was implemented the unique characteristics of rehabilitation facilities were recognized. It was also recognized that the data from which DRGs were constructed did not include information on rehabilitation facilities and cases. Consequently, rehabilitation hospitals and units were excluded from the system and continue to be paid by Medicare on a reasonable cost basis. Under Medicare, rehabilitation hospitals and units are excluded from the PPS if they meet certain tests including having 75 percent of their patients require intensive rehabilitation services for any of the following diagnostic conditions:

- (a) Stroke
- (b) Spinal cord injury
- (c) Congenital deformity
- (d) Amputation
- (e) Major multiple trauma
- (f) Fracture of femur (hip fracture)
- (g) Brain injury
- (h) Polyarthritis, including rheumatoid arthritis
- (i) Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease
- (j) Burns

Currently there are 71 rehabilitation hospitals and 436 rehabilitation units excluded from the Medicare prospective payment system. These facilities represent approximately 17,000 excluded beds. This equates to .008 bed per 100,000 population and .0005 beds per Medicare beneficiary.

All of the foregoing is in way of a preface to addressing the peculiar position of rehabilitation hospitals and units in the application of a change in the method of paying for capital costs of a prospective payment by Medicare.

As noted, we are concerned about the Administration's interest in changing capital payments for exempt entities. We believe, first, that such changes should not be made by regulation, and secondly, that any legislative changes should not be addressed until all the research studies pertaining to all classes of exempt hospitals and units are completed and different form(s) of a prospective payment system for them, other than the target ceiling limitation is considered. Section (b) of S. 2121, which deletes the phrase "with respect to costs incurred in cost reporting periods beginning prior to October 1, 1986," would accomplish this result. However, we suggest an additional phrase be added to read: "Such costs will continue to be paid to Section (d)(1)(B) hospitals and units as paid prior to October 1, 1986."

We also recommend that report language be added that would state clearly that "under Subsection (b), the Committee means that no changes will be made to the method of payment for capital costs for hospitals and units exempt from the Medicare system by the Secretary until Congress so directs the Secretary by legislation to make a change in payments for these entities."

With respect to specific capital issues, many of the observations made to the Subcommittee by other witnesses are valid for rehabilitation. The Administration's proposal for a very quick phase-in of a prospective payment system for capital costs fails to take into consideration the disparate circumstances of hospitals with respect to their capital costs. Such costs vary widely, depending on the age of the facilities and equipment and their mode and cost of financing. Certainly with the considerable fluctuations in interest rates in recent years, hospitals with the same operating characterisitics, occupancy rates and level of efficiency can have very different outlays for their physical plants and equipment. Capital cost is not just an accounting entry for depreciation. It is also dollars to bond holders and other lenders. S. 2121 addresses a longer phase in period.

The Administration's position seems to be that any hospital that undertook a capital investment relying on the cost reimbursement system of Medicare was imprudent and is fair game for an abrupt change in the rules. When capital projects are financed over 20 and 30 year periods, this is not a realistic position. It is particularly ironic when one recognizes that Medicare has by regulation forced hospitals to depreciate capital costs over very long periods as a means of reducing Medicare outlays. One way to harmonize these disparate attitudes would be to provide for the depreciation of all undepreciated capital costs incurred prior to the change in the system over the transition period. If this principle is adopted then the term of the transition period becomes less significant; although were it adopted the merits of a longer transition period would gain considerable appeal for the Administration.

The treatment of previously invested capital by Medicare is of particular concern to rehabilitation hospitals and units because they serve a substantial number of Medicare patients. Clearly, the greater the percentage of Medicare patients, the greater the impact of a change in Medicare treatment of capital cost. Rehabilitation hospitals and units average slightly over 50 percent Medicare patients because of the high incidence of stroke, arthritis and similar conditions among Medicare beneficiaries.

To cushion the impact of such a change on hospitals with exposure to a radical change in government policy, we suggest that a distinction be drawn between previously invested capital and new capital with proper demarcation to account for work in progress. Prior capital and interest expense associated with it should be reduced to current value and depreciated over whatever transition period is selected. New capital can be covered in a transition formula based on replacement cost of the number of beds deemed necessary for inpatient service -- including recognition of specialty services. By such a mechanism the Congress will keep faith with those who have relyed on a system sanctioned by federal law for over 20 years.

Whatever transition mechanism is selected, we urge the Subcommittee to recognize that if a capital factor is to be paid on a prospective per-discharge basis, provision must be made for rehabilitation hospitals and units because of their longer lengths of stay and, therefore, very different capital:discharge ratios. As noted above, lengths of stay in rehabilitation hospitals and units are four to five times longer than in acute facilities. Any per-incident capital cost calculated from acute care data and applied to rehabilitation facilities must be adjusted to reflect this difference. Either a capital cost calculation should be made from cost reports for rehabilitation facilities, or any figure generally derived from general hospitals should be increased by a factor representing the relative lengths of stay of the two types of facilities.

One other feature of the Administration's proposal that deserves comment is the proposal to deduct from Medicare capital payments, however calculated, interest earned by providers on funded depreciation accounts. This concept is wrong. It reflects an intent only to cut federal outlays rather than to deal fairly with the issue. Funded depreciation accounts are for replacement of capital items. Amounts received in depreciation allowances are in repayment of capital spent in the past when, in all recent memory, money had greater purchasing power. Thus, depreciation alone never is equal to replacement cost. Confiscation of earnings on funded depreciation accounts guarantees that hospitals can not accrue, through funded depreciation, the replacement costs of assets being depreciated. The Administration's proposal on this point is fundamentally flawed and should be rejected.

Therefore we urge that the Subcommittee in considering reforming payment for capital expenses under medicare for rehabilitation facilities:

1) Draft legislation prohibiting the Secretary from implementing any new payment methodology with respect to capital related costs of exempt and PPS providers by regulation. Such legislation should also require that the regulations currently in effect for capital payment remain in effect until a change is made;
2) Not consider altering a payment methodology for capital cost for excluded providers until all the studies on exempt hospitals and units are completed and different form(s) of a prospective payment system for exempt entities other than the target ceiling limitation is

considered Subsection (b) of S. 2121 should accomplish this purpose; and

3) When a change in payment for the capital costs of exempt rehabilitation hospitals and units is considered any such change should take into account the longer length of stay of these institutions; distinguish between previously invested and new capital; rely on cost data from rehabilitation facilities; and allow for depreciation of undepreciated capital costs during the transition period.

We would be pleased to discuss these points with you.

We hope the Subcommittee will be congnizant of these considerations. A capital plan that fails to deal adequately and fairly with the return and cost of capital will have serious adverse effects on both rehabilitation hospitals and patients.

John A. Doyle
Executive Director

STATEMENT BY THE NATIONAL ELECTRICAL MANUFACTURERS ASSOCIATION

TO THE SENATE FINANCE HEALTH SUBCOMMITTEE

HEARING ON MEDICARE CAPITAL REIMBURSEMENT

MARCH 14, 1986

As the representative of manufacturers of capital medical equipment, the National Electrical Manufacturers Association* (NEMA) is gravely concerned over consideration given at the Health Subcommittee's March 14th hearing on Medicare capital reimbursement to the proposal to accord different treatment to different medical equipment.

Initially, NEMA encourages the initiative of Senators Durenberger and Quayle to find a legislative answer to incorporating capital into the prospective payment system (PPS), S. 2121, the "Fair Deal Capital Payment Act." Not only was it apparent that it was Congress' intent when PPS was implemented that the decision on how capital would be reimbursed was a matter for Congressional purview, but it is also apparent that Congress is much more sensitive to the needs of hospitals and manufacturers than the Administration has evidenced. The Administration's interest in using a change in the payment system for capital as a vehicle to save additional Medicare budget dollars has overridden concern for the hospitals and manufacturers that will be severely harmed by its proposal.

For this reason, we urge the Congress to immediately pass legislation to make clear that no prospective payment plan for Medicare capital costs can be implemented without Congressional approval.

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*NEMA is the principal trade association of the electrical manufacturing industry. The Association has some 570 member manufacturing companies which are affiliated with one or more of its product Divisions, each Division representing in essence a separate and distinct industry. The electrical products within NEMA's scope are used either as components or as end-equipment in all major phases of the generation, transmission, distribution, control and utilization of electrical energy.

Although S. 2121 does not treat the capital costs of moveable equipment differently from other capital costs, questions regarding such an approach were raised by the Committee at the March 14 hearing. It has been proposed that capital costs for moveable equipment be incorporated into the DRG payment system without any transition from the current cost reimbursement system.

We can see no valid reason for such treatment of equipment capital costs. Although equipment is depreciated over a shorter period than facility costs, it is still a long term investment decision that should be accorded a reasonable adjustment period. Considering that even the shortest term costs of operating expenses were accorded a multi-year phase-in to prospective payment in the Social Security Amendments of 1983, certainly hospitals' investment in capital technology should be granted a similar transition period.

In practical terms, separating the capital costs of moveable equipment from plant and fixed equipment is an extremely complex task, and one of questionable value. Both Department and outside experts have testified that such separation of costs is so administratively complex that it is difficult to justify.

NEMA fears that singling out medical equipment for different prospective payment treatment would in effect penalize a hospital for investing in medical technology, a consequence we are certain is not desired by the Congress.

The provisions of the "Fair Deal Capital Payment Act" provide a framework for a more rational and equitable approach to Medicare payment of its fair share of hospital capital costs. NEMA is concerned however over the uncertainty regarding the availability of data to establish a "national average standardized capital amount." Extensive delays in obtaining Medicare cost and/or charge data is a characteristic of the Medicare system. Thus the base year for calculating the national capital payment amount may be a number of years prior to FY 1987, with no clearly adequate mechanism for updating such an early year to its current, or 1987 value. We suggest therefore, that consideration be given to using the available actuarial estimates of Fiscal Year 1987 hospital capital expenditures, and making subsequent adjustments to correct for any minor actuarial errors.

We would also like to reiterate our suggestion that any proposal that is finally implemented be monitored carefully by Congress to assess its effectiveness. Because the proposal must be based on incomplete data and because the entire prospective payment system has not been implemented as smoothly as was anticipated, this monitoring will be a necessary safeguard.

UNIVERSITY HOSPITAL
at Boston University Medical Center

ANALYSIS OF PROPOSALS TO MODIFY MEDICARE REIMBURSEMENT FOR CAPITAL EXPENSES

Prepared for Hearing
of
Subcommittee on Health, Committee on Finance
U.S. Senate
March 14, 1986

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EXECUTIVE SUMMARY

This paper is University Hospital's analysis of three proposals to incorporate capital costs into Medicare's Prospective Payment System. These proposals should be substantially modified because their implementation would cause significant financial hardship for many efficiently run hospitals--especially tertiary teaching hospitals--and will cause difficulty for many hospitals in meeting obligations to bondholders.

To project the effects of these proposals, University Hospital ("UH") has analyzed its own financial data and comparable information for five additional major Boston tertiary teaching hospitals.[1] These hospitals represent a national, regional and state center of superior medical service, education, training and research, serving as the principal teaching hospitals of Boston University School of Medicine, Harvard Medical School and Tufts University School of Medicine. They also provide employment to more than 26,000 people, representing a payroll of over $500 million annually.

The implementation of proposed capital payments under Medicare's Prospective Payment System will have a deleterious effect on the group of hospitals studied, despite their high average occupancy rate of 84 percent. An analysis based on the draft proposal prepared by the Department of Health and Human Services (circulated in October, 1985) shows that the six hospitals would experience an aggregate $5.5 million reduction in Medicare reimbursement in an average year during the proposed seven-year phase-in period. After the system is fully implemented, the aggregate annual loss for the six hospitals would be more than $16.8 million. (University Hospital would lose $1.6 million annually during the transition and $4 million annually thereafter.)

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[1] Hospitals that were studied are the following: Beth Israel Hospital, Brigham and Women's Hospital, Massachusetts General Hospital, New England Deaconess Hospital, New England Medical Center Hospitals and University Hospital.

University Hospital has identified major problems that are common to all three proposals and are responsible for these significant losses:

1. Tertiary Teaching Hospitals: By limiting capital reimbursement to average costs, the proposals fail to recognize the above-average capital costs inherent in the high-intensity patient care, state-of-the-art technology and medical-training functions of the tertiary teaching hospitals. Use of the average may undermine the superior quality of care, the advancement of medical science and the preparation of future generations of health professionals that take place at these institutions.

2. Transition Period: Because hospital bond commitments are generally far longer than the proposed phase-in periods, many hospitals will not be able to reduce their major capital costs to adjust to the new reimbursement system. Particularly affected will be hospitals with recent capital investments (i.e., those institutions with "younger capital"). By using average capital costs, the proposals cause losses to hospitals with newer facilities (and therefore higher capital costs). Hence, even if a hospital is efficient and maintains high occupancy rates it may be unable to respond to the new system's demands. This may cause some hospitals to be unable to meet their obligations to bondholders.

We recommend that Congress develop a prospective payment plan that provides:

1. An adjustment to compensate teaching hospitals for their additional capital costs. We recommend an increase in the capital payment of 1 to 2 percent.

2. A realistic transition. Hospitals must be allowed a sufficient time to adjust their capital costs to respond to the new system of capital reimbursement. In particular, hospitals with younger capital should not be put in a situation to which they cannot respond. Two alternative approaches are recommended, which may be applied independently or in tandem:

   - Medicare capital payments should be indexed to an individual hospital's currently existing level of outstanding fixed debt, contingent upon maintenance of high occupancy rates. The capital payment should be multiplied by an index value greater than one but not greater than the value providing full cost replacement. The intent of this approach is to have any disincentives in the reimbursement system target inefficient providers rather than those institutions with younger assets.

   - The length of the transition period should be extended for those hospitals with substantial debt financing. An appropriate period of time might be 12 to 15 years, or half the average time remaining on outstanding major bond commitments. The intent of this alternative is to have the phase-in period bear a realistic relationship to the length of fixed bond commitments.

INTRODUCTION

In preparation for this hearing of the Subcommittee on Health, Committee on Finance, staff of University Hospital at Boston University Medical Center analyzed the effects of three proposals that have been discussed to incorporate capital costs into Medicare's Prospective Payment System. The analysis examined the effects such proposals would have on Boston's six key nonspecialized tertiary teaching hospitals: Beth Israel Hospital, Brigham & Women's Hospital, Massachusetts General Hospital, New England Deaconess Hospital, New England Medical Center Hospitals and University Hospital itself. These six voluntary, not-for-profit hospitals have an aggregate complement of nearly 3,600 beds and annual operating expenses totaling more than $1 billion; in 1985 they served over 124,000 inpatients while maintaining inpatient occupancy levels averaging 84 percent. These six hospitals provide employment to more than 26,000 people with a resulting payroll of more than $500 million annually.

For the year ended September 30, 1985, these institutions had total revenues of $1.145 billion, with an operating income of $10.5 million. This represents an operating margin of only 0.9 percent, in comparison to a national operating margin of 2.6 percent. Despite the large size of these institutions, their profitability margin is very narrow and extremely vulnerable to changes in the reimbursement mechanisms that affect them.

The six hospitals that were studied provide acute-care services and serve as tertiary referral centers for a wide range of the city, state and national communities. They are the major teaching hospitals for the medical schools of Boston University, Harvard University and Tufts University, offering extensive educational services to medical students, resident physicians, and established practitioners. Each conducts a sizeable sponsored-research program responsible for advances in diagnosis and therapy that are of international renown and major human and economic significance. Collectively and individually, these hospitals have a nearly 200-year heritage of consistent excellence in patient care, in the education and training of health professionals, and in medical research.[2]

These six Boston teaching hospitals have made a significant investment in their facilities for providing patient care. On September 30, 1985, their property, plant and equipment totaled $1.066 billion, with accumulated depreciation of $320 million. This fixed-asset investment was financed through equity bonds and through debt. On September 30, 1985, these six hospitals alone had remaining debt obligations of $468 million. The debt, which consists primarily of tax-exempt revenue bonds, was incurred with the expectation that the reimbursement system would provide the cash flow to meet the required repayment of the bondholders.

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[2] Exhibit 1 is a profile of Six Boston Teaching Hospitals, prepared in 1983 by Coopers & Lybrand. Five of the hospitals studied in this analysis were participants in the 1983 profile.

THE PROPOSED PLANS

Three plans have been proposed to incorporate capital costs into the Prospective Payment System. The first is a draft report to Congress prepared by the U.S. Department of Health and Human Services (HHS) in October, 1985.[3] The second is included in the Administration budget for FY 1987. The third proposal, S. 2121, is cosponsored by Senators David Durenberger (R.-Minn.), chairman, Health Subcommittee, Senate Finance Committee, and Daniel Quayle (R.-Ind.). The bill was introduced February 27, 1986. In general, all three these plans share these common objectives:

- To create incentives for hospitals to engage in efficient, business-like capital spending programs.
- To create a uniform PPS rate for ease of administration and to eliminate perverse incentives contained in a dual payment system.
- To adequately reimburse hospitals so as to ensure high quality care for Medicare patients.
- To provide a transition period allowing hospitals time to adjust their capital costs to meet the new environment.

To implement these goals, HHS proposed in its draft report to Congress a uniform national PPS rate beginning in Fiscal Year 1994. The capital portion of the rate would be based on national average capital costs per discharge. The transition to this national average rate would begin in Fiscal Year 1987 through a seven-year phase-in; in each year between 1987 and 1994, a hospital's capital reimbursement would be based in decreasing proportions on the hospital's own costs:

YEAR	HOSPITAL-SPECIFIC PROPORTION	NATIONAL AVERAGE PROPORTION
1987	95%	5%
1988	90%	10%
1989	80%	20%
1990	65%	35%
1991	50%	50%
1992	30%	70%
1993	10%	90%
1994	0%	100% (Full Implementation)

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[3] Department of Health and Human Services, Office of Assistant Secretary for Planning and Evaluation, Hospital Capital Expenses: A Medicare Payment Strategy for the Future, October, 1985.

Unfortunately, the Office of Management and Budget rejected these recommendations, and instead the Administration opted for a more stringent approach. At the budget briefing conducted on February 5, 1986, HHS Secretary Otis Bowen, M.D., emphasized that Medicare payments for capital costs would be phased into the Prospective Payment System over the next four years. The Administration plan, which will be issued as a proposed regulation in early June, 1986, is projected to reduce budget outlays $456 million in Fiscal Year 1987 and $4.2 billion over three years.

When this new system is fully implemented in 1991, each PPS hospital would be paid a fixed, all-inclusive rate that includes both capital and operating costs for each Medicare admission. The capital portion would be added to the current operating standardized amounts and multiplied by the appropriate DRG weight to produce a total payment per case.

There will be a four-year transition period with the payment amounts being composed of a blend of a hospital-specific cost-based portion and a federal part based on a national average. For FY 1987, the blend would be 80 percent hospital-specific and 20 percent federal; by Fiscal Year 1991, the rate would be 100 percent federal.

The Durenberger/Quayle bill, S. 2121, is comparable to the draft proposal developed by HHS in October, 1985. There would be a seven-year transition period effective for fiscal years beginning on and after October 1, 1986, and ending October 1, 1993. Reimbursement for capital would consist of blended proportions of a hospital-specific pass-through and a national standardized average payment amount. By October 1, 1993, all capital expenses would be 100-percent federal. The blending percentages are those suggested in the HHS recommendation (see page 4 above).

The hospital-specific portion would be based upon each hospital's current capital costs during each year of the transition, rather than on costs during a fixed base period, as the Administration proposed in the budget.

S. 2121 would use a fixed base year--the most recent fiscal year for which adequate data are available--for calculating the federal capital rate. The national standardized average capital payment rate would be adjusted for the following purposes: to offset interest expense with interest income; to eliminate return on equity; to reflect local construction costs associated with depreciation of physical plant; and to recognize changes in the cost of capital since the base year. The national rate would be adjusted by an appropriate capital marketbasket inflation factor.

FINANCIAL IMPACT

Implementation of any of the above proposals will cause serious reimbursement losses to University Hospital and to the community of Boston's tertiary teaching hospitals. Based on preliminary analysis, University Hospital concludes that even the least onerous mechanism, suggested in the HHS draft proposal, would cause Medicare capital reimbursement losses as follows:

- over $1.6 million on average annually during phase-in for University Hospital and over $4 million annually for University Hospital thereafter

- over $5.5 million on average annually for the six hospitals in aggregate during the seven-year phase-in

- over $16.8 million annually for the six hospitals in aggregate after full implementation

As shown in Table 1, these six hospitals would experience in total an estimated $38.7-million reimbursement shortfall over seven years under the HHS proposal. (Losses under S. 2121 should be comparable because of the similarities in the plans.) This shortfall was calculated assuming a national capital/operating cost ratio of 7.4 percent and without reduction for income from funded depreciation. Further reductions in the national rate will increase the losses to the teaching hospitals.

These resulting losses demonstrate the unreasonableness of the proposed system, in that its incentives and penalties are not based on a given hospital's efficiency. In fact, the six Boston teaching hospitals are highly efficient--with average 1985 occupancy over 84 percent (compared to a 1984 national average of 69 percent)--and provide high quality, high intensity care to large numbers of Medicare patients (approximately 45,000 in 1985).

Although it is difficult to predict the effects of the proposed system, there are likely to be unintended consequences. Most notable among these are the possible damage to bondholders and the resulting increased interest costs of future hospital capital investments. Table 2 shows projected interest and principal requirements for University Hospital and the additional five Boston tertiary teaching hospitals, based upon the published and/or supplied data.

The largest losses caused by the proposed system will accrue to hospitals with younger assets. Generally, these are hospitals that have recently made major capital investments and therefore have high levels of bond or mortgage debt with fixed obligations. The large losses to be experienced by Boston teaching hospitals with recent capital investments may make it difficult for them to meet their fixed debt payments, thereby endangering the investments of bondholders and mortgage investors throughout the country. In turn, the increased risk to debt holders may result in lower bond ratings and increased interest rates for future investments.

There may be other unexpected and unintended consequences. Because their capital costs are fixed, some hospitals will be forced to resort to cuts in operating expenses, which could significantly diminish the quality of care or range of services to Medicare patients. On the other hand, some hospitals with older facilities may receive payments that may help them resist economic pressures to improve or close despite low occupancy rates and inefficiencies.

Table 1

Analysis of Capital Reimbursement Proposals Projected Losses in Reimbursement for Six Boston Teaching Hospitals*

	1987	1988	1989	1990	1991	1992	1993	1994	1995
					(In Thousands)				
University Hospital	$ 34	$(265)	$ (830)	$(1,477)	$(2,102)	$(2,931)	$ (3,751)	$ (4,146)	$ (4,122)
Other Five Teaching Hospitals	(302)	(583)	(1,130)	(3,536)	(4,633)	(6,336)	(10,846)	(12,196)	(12,740)
	$(268)	$(848)	$(1,960)	$(5,013)	$(6,735)	$(9,267)	$(14,597)	$(16,342)	$(16,862)
Range:									
High	$ (150)	$ (300)	$ (830)	$ (1,477)	$ (2,102)	$ (2,931)	$ (5,940)	$ (6,685)	$ (7,130)
Low	$ 34	$ 71	$ 153	$ 182	$ 619	$ 930	$ 996	$ 904	$ 651

Table 2

Projected Principal and Interest Requirements for Six Boston Teaching Hospitals

	1987	1988	1989	1990	1991	1992	1993	1994	1995
					(In Thousands)				
University Hospital	$ 986	$ 7,523	$ 9,354	$ 9,482	$ 9,442	$ 9,439	$ 9,442	$ 9,443	$ 9,442
Other Five Teaching Hospitals	38,827	38,830	37,951	46,720	46,740	45,044	50,195	51,175	49,945
	$39,813	$46,353	$47,305	$56,202	$56,182	$54,483	$59,637	$60,618	$59,387
Range:									
High	$9,658	$10,183	$10,181	$16,713	$15,774	$15,874	$21,666	$22,032	$22,397
Low	$ 986	$3,954	$3,216	$2,932	$3,954	$2,222	$1,652	$2,349	$1,179

*Based on Department of Health and Human Services proposal of October 1985

PROBLEMS AND PROPOSED SOLUTIONS

The analysis conducted by University Hospital has revealed three major problems that prevent the proposals from meeting their stated goals:

- Current proposals fail to meet the special and necessary additional capital costs incurred by tertiary teaching hospitals.
- Current proposals do not allow adequate time for hospitals with high levels of fixed debt payments to make the adjustment to a uniform national rate.
- As a result of the timing issue, current proposals apportion gains and losses on the basis of existing capital investment levels, rather than efficiency.

The following sections elaborate on these concerns and recommend a course of action to ameliorate the problems.

• THE SPECIAL NEEDS OF TERTIARY TEACHING HOSPITALS

A major problem with the current proposals is that, by limiting capital reimbursement to average costs, they fail to recognize the legitimate above-average capital costs of the tertiary teaching hospital. These costs are inherent in the high-intensity patient care, state-of-the-art technology and medical training functions that take place in tertiary teaching hospitals. Failure to recognize these legitimate costs may damage these essential services. The current graduate medical education reimbursement methodology specifically excludes the capital costs for medical education.

The greater capital dependency of tertiary teaching hospitals arises from the need for larger plant size and from greater equipment needs. Tertiary teaching hospitals require more space per patient bed than a community hospital in order to accommodate additional bedside equipment, educational functions, and more professional personnel. In addition, the greater casemix intensity of tertiary hospitals increases the need for isolation rooms, intensive care facilities and specialty treatment and operating rooms.[4]

Tertiary teaching hospitals also generally have a broader and more comprehensive range of on-site equipment, caused, in part, by the initiatives of the health planning process and the need of teaching hospitals to maintain state of the art equipment. Additionally, because of the higher use rates of high-technology equipment in tertiary teaching hospitals, there is a higher level of obsolescence, increased equipment turnover and higher total capital costs.

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[4] The Association of American Medical Colleges has demonstrated a significantly higher level of capital costs per work load unit (adjusted admission) in teaching hospitals. In 1982, depreciation and interest totaled $306.99 per work load unit (adjusted admission) in teaching hospitals, compared with $139.59 in nonteaching institutions. James O. Bentley, Toward an Understanding of Capital Costs in COTH Hospitals, March 27, 1984.

These additional capital expenses are legitimate and necessary to maintain the clinical and educational functions of tertiary teaching hospitals; for these institutions to remain viable, such costs must be recognized and reimbursed by the Medicare system. Therefore, University Hospital recommends that any new Medicare capital reimbursement mechanism under PPS be modified to assure an adjustment that adequately reimburses the capital costs of teaching hospitals. This is particularly important since the current graduate medical education add-on does not incorporate the capital cost element. Reimbursement for teaching costs must include the capital costs associated with graduate medical education programs.

RECOMMENDATION: Provide an adjustment to compensate teaching hospitals for their added capital needs. We recommend an increase in the formula of 1 to 2 percent.

METHOD: An adjustment should be paid to tertiary teaching hospitals to allow a given percentage of additional costs, based on the number of residents (Full Time Equivalents) per bed. The appropriate adjustment could be 1 to 2 percent, derived from a comparison of Medicare capital costs per adjusted admission for teaching and nonteaching hospitals.[5] This proposal has the advantage of ease of administration; once initial levels are established, it can be administered as part of the current Graduate Medical Education add-on calculation. Moreover, this proposal does not increase aggregate Medicare expenditures on capital costs; rather, it redistributes the same payments on a basis that is more equitable and reflects the quality and intensity of care provided by these hospitals.

- VARIATIONS IN THE CAPITAL CYCLE

University Hospital recognizes the need to incorporate capital into the Medicare Prospective Payment System. The current proposals, however, do not give adequate consideration to the extreme hardship inherent in the process of making the transition from cost-based reimbursement to a uniform national rate. As drafted, the proposals apportion gains and losses to hospitals based on the timing of capital construction and investment, forcing losses onto newer facilities regardless of efficiency. Unless current proposals are substantially modified to smooth this transition, the shift to the proposed system will cause serious and protracted payment problems for University Hospital, similar hospitals, and their associated bondholders.

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[5] The aforementioned study of capital costs in teaching hospitals and nonteaching hospitals by the Association of American Medical Colleges (March 27, 1984) on estimated capital costs per admission is the basis of this adjustment estimate.

The current proposals threaten to harm hospitals substantially because, unlike their control of operating costs, most hospitals have little control over capital costs in the short-run. Hospitals with substantial debt financing--especially those employing long-term bonds--are often contractually bound into 25- to 35-year fixed repayments. Consequently, hospitals with substantial levels of debt financing will be unable to make reductions in capital costs to respond to reduced Medicare capital reimbursement. In many cases, such hospitals will be forced to absorb multimillion dollar losses annually.

This problem is most damaging to hospitals that have recently incurred large amounts of debt to finance new capital projects. These are frequently the hospitals with the highest capital costs; yet because of the long-term nature of their bond issues, these hospitals are also the least able to exercise capital cost control. Once an institution has made multimillion investments in plant and equipment--and incurred substantial long-term debt--management cannot turn back. Yet these hospitals will face substantial cutbacks in Medicare capital payments under the proposed system.

University Hospital at Boston University Medical Center serves as a prime example of this problem. In 1984, after years of conservative spending for fixed assets (UH's aggregate asset age is between 12 and 40 years, depending on the measure used), UH received approval from the state's Determination of Need Program to begin a major capital construction and renovation project. A partial replacement building, scheduled to open in January, 1988, is financed by a 35-year, $76.9-million bond issue, with fixed interest and principal payments scheduled through the year 2019.

Because of the age of its facilities, UH has been able to maintain relatively low capital costs--and capital reimbursement. In 1988, when its replacement building opens, UH will experience a significant increase in capital costs; under the currently proposed mechanisms, however, UH will not be able to recoup Medicare's full share of these capital costs. This will result in a loss to UH of over $4 million annually after the HHS proposed seven-year transition period (see Table 1).

RECOMMENDATIONS: UH offers two alternative recommendations to ameliorate the problems that a uniform Medicare capital add-on will cause hospitals with new major capital projects--and their bondholders. One alternative deals with the length of the phase-in period; the second addresses the level of fixed debt.

1. Length of Phase-In Period: University Hospital proposes that the length of the period for phase-in to the uniform capital payment be extended for those hospitals with substantial debt financing. To implement this approach, a schedule would be established specifying varying lengths of phase-in based on the individual hospitals' amount of long-term debt as a percentage of total assets. Hospitals

with very high percentages of debt financing would be allowed a longer adjustment period, commensurate with the length of bond commitments. For example, an appropriate period of time might be 12 to 15 years, for the most recent capital additions, or half the average time remaining on outstanding major bond commitments. To assure that this approach does not inappropriately protect inefficient hospitals, Congress could make this extended phase-in contingent upon a hospital's achievement or maintenance of high occupancy rates.

While this recommendation would not eliminate all losses caused by the transition to a uniform capital payment under prospective reimbursement, it would smooth the transition and diminish underpayments/shortfalls experienced by hospitals with newer facilities. At the same time, the majority of hospitals will be able to make the more rapid transition into the uniform capital rate.

2. Fixed Debt Payment Index: This recommendation would index Medicare rates to an individual hospital's level of outstanding fixed debt. We recommend that the capital payment be multiplied by an index with a value greater than one but not greater than the value providing full cost replacement for the hospital-specific portion. Hospitals with high levels of fixed debt would receive increased reimbursement to compensate for their higher capital costs. To eliminate incentives for new spending and allow for a natural phase-out of this transitional mechanism, Congress could specify that debt incurred after a certain date (e.g., 1986) would not be eligible for consideration as "fixed debt".

   The major advantage of this recommendation is that it would apportion greater payments to those hospitals that have contractually fixed costs and are therefore less able to respond rapidly to the changing environment. In addition, this recommendation would be relatively easy to administer and would rationalize incentives involved in capital spending.

Both of the above recommendations are specifically designed to enable the hospitals to meet existing commitments to bondholders. As shown in Table 2, the six Boston tertiary teaching hospitals alone have projected interest and principal payments primarily to bondholders of $360 million during the next seven years, with significant amounts thereafter. We believe that the mechanism incorporating capital costs into the Prospective Payment System must provide for existing commitments to bondholders.

CONCLUSION

In conclusion, University Hospital finds that the current proposals do not meet their stated objectives for three reasons. First, they fail to recognize the additional capital investments required by tertiary teaching hospitals. Second, the proposals do not allow hospitals adequate time to adjust to a new reimbursement system. Third, the timing issues create unintended and counterproductive results by putting hospitals with younger assets (regardless of efficiency and occupancy) in economic straits to which they will be unable to respond, and similarly by providing potential extra benefits to hospitals with older assets (again regardless of efficiency or occupancy). Consequently, Boston tertiary teaching hospitals will experience substantial reimbursement losses--despite the high occupancy rates of these institutions.

Our concerns are based on the resources needed by tertiary teaching hospitals to provide superior medical service, education, training and research. In addition, we seek to prevent unintended economic problems for hospitals with high fixed-asset levels that cannot be modified in short time frames. University Hospital at Boston University Medical Center is firmly convinced that adoption of its recommendations on capital will ameliorate potential problems of teaching hospitals as well as other hospitals and help ease the difficult transition to a new reimbursement system.

EXHIBIT 1

PROFILE OF SIX BOSTON TEACHING HOSPITALS

In 1983, six Boston teaching hospitals commissioned a study by Coopers & Lybrand to profile the services, financial characteristics and economic impacts of an aggregated entity, the "Six Boston Teaching Hospitals." Five of the hospitals studied for this analysis were represented in the 1983 study. The attached Profile is included to offer a concise summary of the scientific and medical advances initiated in Boston's tertiary teaching hospitals.

Six Boston Teaching Hospitals

A profile of the services, financial characteristics, and economic impacts of "Six Boston Teaching Hospitals," based on a study commissioned by:

Beth Israel Hospital
Brigham & Women's Hospital
The Children's Hospital
Massachusetts General Hospital
New England Medical Center
and
University Hospital at Boston University Medical Center

Study conducted by:
Coopers & Lybrand
Study Overview prepared by the sponsors

December, 1984

INTRODUCTION

Public scrutiny of America's hospitals has heightened out of concern over the costs of health care and the appreciation that we are in a time of dramatic change in both the delivery and financing of care as well as in its technological sophistication. Teaching hospitals are being challenged additionally to delineate the value of their teaching, training, and research programs, and their innovation and aggregation of specialized technology. Responding to these concerns, six major teaching hospitals in Boston commissioned a study to identify their collective impact in the City of Boston, the Commonwealth of Massachusetts, and beyond. The six hospitals are Beth Israel Hospital, Brigham & Women's Hospital, The Children's Hospital, Massachusetts General Hospital, New England Medical Center, and University Hospital at Boston University Medical Center. Located in the City of Boston and holding key affiliations with Boston medical schools, each is voluntary and nonprofit, provides general acute-care services to a wide range of the city, state, and national communities, and offers extensive teaching to medical students, training to resident physicians, and continuing education to established practitioners. Each conducts a sizeable sponsored research program responsible for advances in diagnosis and therapy that are of international renown and major human and economic significance.

The study aggregates audited financial information and supplemental financial, operational, and employment data from the six hospitals to present the collective impact of a consolidated entity, "Six Boston Teaching Hospitals." The detailed report presents the patient-care, research, and educational achievements of the six hospitals; summarizes aspects of their patient-care activities; and reviews their financial characteristics alone and in comparison with other hospitals in the Commonwealth and the nation, and with other industries.

The unquestionable major economic impact of the Six Boston Teaching Hospitals may surprise some readers. The impact of the hospitals on the area's businesses is as noteworthy as is their influence on health care. This economic impact must be taken into account as regulation from without and competition from within evolve in response to the changing environment of health care financing and delivery.

Collectively and individually, the Six Boston Teaching Hospitals have a nearly 200-year heritage of consistent excellence in patient care, in the education and training of health professionals, and in medical research. The study examines these institutions in terms of economic impact, service provided, and quality of management.

ECONOMIC IMPACT

The six hospitals exercise a profound economic impact, in both the City of Boston and the Commonwealth of Massachusetts, in terms of employment, goods and services purchased, the care provided to the medically indigent, and the substantial economic and human resources attracted from outside the Commonwealth. Collectively, the Six Boston Teaching Hospitals * --

- employ 27,500 persons, of whom 15,000 live in Boston (1,800 are physicians). These 15,000 represent 5.7 percent of all employed Boston residents. Eighteen percent of all employees are members of minority groups.
- have a payroll of over one-half billion dollars, of which $370 million is directed to Boston residents.
- pay $183 million in employment taxes (federal, state, and FICA) .
- purchase goods and services of $387 million, most of it from businesses in Boston and Massachusetts.
- attract sponsored research funds, primarily from the federal government, foundations, and national and international industry. In 1983, the total of such awards was $127.5 million, a 42-percent increase over the 1980 level. At the six teaching hospitals, more than 3,500 researchers and staff are employed in these efforts alone.

In addition, the six teaching hospitals provided $57.1 million in "uncompensated care" in 1983, which is 26 percent of the uncompensated care provided by all Massachusetts hospitals. (Uncompensated care represents the free care provided to

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* Data based on 1983 information

patients who are unable to pay, as well as any bad debts.) The figure excludes the discounts provided Medicare, Medicaid, Blue Cross, and certain other third-party payers. Most of the free care and bad debts derive from care provided the medically indigent or others who cannot pay for hospital services, many of whom are Boston residents. Uncompensated care is actually paid for by those few who pay somewhat more than cost, and also from hospital philanthropy and hospital endowment interest. If these three sources were not available, much of the burden would inevitably shift directly or indirectly to Massachusetts business and industry.

SERVICES PROVIDED

Patient Care: Collectively, the Six Boston Teaching Hospitals provide a comprehensive array of clinical services, with 3,470 beds including 362 devoted to intensive care. Bed utilization tends to be higher than that of most community hospitals, reflecting the role of these Boston institutions as "court of last resort" for the most complex and problematic cases. This responsibility is reflected in the relative growth of intensive care beds: While total bed complement of the six hospitals has grown less than one percent since 1981, the complement of intensive care beds grew by seven percent, through conversion of existing standard medical/surgical beds and addition of newborn intensive care bassinets. Reflecting that shift in facilities is a slight decline in patient days (excluding intensive care), from 1,033,957 days to 1,017,654 days or 1.64 percent from 1981 to 1983, while intensive care days increased by 10.16 percent, from 94,440 days to 104,039 days in the same period. The wide service area is illustrated by the fact that only about one-third of inpatients are Boston residents, while about 57 percent reside elsewhere in Massachusetts and another 12 percent are residents of other states and countries. There is also a strong community focus, however, best seen in the ambulatory care and outreach programs. In 1983, over a million hospital-based clinic visits were recorded and an additional 270,000 visits were made to related nearby off-site clinics and community health centers. These six teaching hospitals provide 14.2 percent of all inpatient admissions and 12.4 percent of all hospital outpatient visits in Massachusetts.

Training: The Six Boston Teaching Hospitals offer 342 approved physician training programs in conjunction with the three Boston medical schools, including virtually every category of graduate training approved by the American Medical Association, the American Dental Association, and various specialty organizations. More than 1,600 interns, residents, and fellows were engaged in these programs in 1983. Thirty schools of nursing were affiliated with the six hospitals in that same year, involving the preparation of more than 1,100 registered nurses and 75 licensed practical nurses. More than 70 additional allied health training programs are in operation, training for such roles as physical therapist, occupational therapist, x-ray technician, and emergency medical technician; 720 students were involved in these programs in 1983. Ongoing educational programs fill the day at all six institutions for the benefit of both hospital-based medical staff and practitioners in the community; it is here in the major teaching hospitals that standards of care are established, monitored, and continually updated and refined.

OPERATING MANAGEMENT

In an increasingly restricted economic environment, the Six Boston Teaching Hospitals have continued to provide services of the desired quality and quantity, largely through strengthened administrative and clinical efficiency of operation. For example, in a regulatory environment allowing only a limited operating margin, the six hospitals have been replacing aging physical plants, a critical necessity given the high-technology services needed for the tertiary-care, referral patient. The six hospitals have led the way in the effective Massachusetts cost-control effort under Chapter 372. In several instances, better-than-expected bottom lines resulted from both stringent management operating controls in response to Chapter 372, and the lower-than-anticipated rate of inflation of the hospitals' expenses in the first years of operation of Chapter 372.

WHAT OF THE FUTURE?

The future poses serious challenges to the financial integrity of the Six Boston Teaching Hospitals, above and beyond the general risks for all Massachusetts hospitals.

- The regulated "productivity factor" reductions of seven percent ordained through 1988 by Chapter 372 will erode current operating margins. Representing (in 1983 dollars) some $70 million in revenue reductions, this factor will compromise the capability of these institutions to develop the "seed money" to establish new clinical programs, including new efforts for the poor. Nonoperating revenue sources are unlikely to cover anticipated shortfalls.

- As the bottom line wanes, access to capital will become increasingly restricted. Present superior credit strength may decline and interest rates on borrowed money may rise.
- The combination of more stringent regulation of payment for care and increased economic competition seems inevitable. These conflicting trends will be made even worse by a growing severity -- perhaps even arbitrariness and clinical irresponsibility -- of externally imposed utilization management controls designed to yield additional cost reductions. As operating flexibility becomes increasingly constricted, further curtailment of the expense budget will forebode a decline in quality of care, diminution of the specialized services which have placed these hospitals among the nation's leaders, and significant erosion of their employment and purchasing power. The balance of interests that shape these teaching hospitals' programmatic roles must therefore forge both the financial restraints and the encouragements that will direct them to meet fairly the responsibilities they have thus far fulfilled. To do so requires the understanding and support of a knowledgeable community. The alternative is a loss of those very qualities that help attract businesspeople to this Commonwealth.

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